

Washington State Medical Cannabis Legal Guide



CANNABIS
DEFENSE
COALITION

Introduction

About this Document

This is a guide to medical cannabis law and best practices in Washington State. It is intended to assist qualifying patients and those who facilitate access to their medical cannabis, as well as governmental bodies wishing to better understand the reality of medical cannabis delivery systems in Washington State. Each chapter covers a specific role or component of the Washington State medical cannabis universe. While following the law and these suggestions will help if one has the misfortune of being prosecuted by the state over a botanical flower, none of this is a “silver bullet,” and it certainly should not be construed as qualified legal advice.

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About the Coalition

Cannabis Defense Coalition is a 501(c)(3) member cooperative focused on cannabis activism in Washington State. Our core activism is tracking and observing medical cannabis trials across the state. Additionally, we take on a dozen or more different projects each year in defense of the cannabis plant and rational drug policy. To get involved, visit www.cdc.coop and sign up for our weekly email alerts, or attend the monthly meeting. We meet the first non-holiday Monday of the month in Seattle.

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Washington Cannabis History

Before I-692

January 20, 1972

I-264 filed to liberalize Washington State cannabis laws.

November 26, 1976

U.S. v. Randall recognizes medical necessity defense for cannabis.

1978

Federal government starts Compassionate Investigational New Drug (IND) Program.

1979

Washington State passes HB 259, creating the Controlled Substances Therapeutic Research Act.

August 17, 1991

Inspired by Jack Herer's book "The Emperor Wears No Clothes," Gary Cook promotes the first annual Seattle Hempfest, originally billed as the Washington Hemp Expo.

November 5, 1991

San Francisco passes Proposition P medical cannabis initiative with a 79% vote.

1992

George Bush shuts down IND Program due to increasing number of AIDS applicants.

Fall 1993

Green Cross Patient Co-op founded on Bainbridge Island.

1993-1998

Hemp Initiative Projects of Washington State runs legalization initiatives.

1994

Joanna McKee presents 834-signature petition to the Bainbridge City Council.

1994

Washington Hemp Education Network founded by Dave Hall.

April 20, 1995

Robert Lunday creates Hemp.Net to connect the Washington drug policy movement.

May 3, 1995

Green Cross raided.

October 13, 1995

Pierce County court declares medical cannabis ban unconstitutional in case brought by pro se litigant Ralph Seeley.

March 8, 1996

WA legislature enacts SB 6744, creating but not funding two Washington State University medical cannabis studies.

Fall 1996

Seattle Hempfest takes a year off to produce first ever Washington Hemp Voter's Guide.

September 25, 1996

Washington Supreme Court hears oral arguments in Seeley v. State.

November 5, 1996

Proposition 215 passes with 55% of the vote in California.

January 3, 1997

Jury hangs in case against patient activist Martin Martinez, who raised a common law medical necessity defense. Codefendant Danielle Buckley is acquitted.

July 24, 1997

WA Supreme Court overturns Seeley v. State, 8-1.

November 4, 1997

I-685 “drug medicalization” initiative fails

January 21, 1998

Ralph Seeley dies in Tacoma.

February 5, 1998

Senate Joint Memorial 8030 introduced to ask the federal government to downgrade cannabis to Schedule II.

February 11, 1998

Medical cannabis bill SB 6271 dies in committee.

November 3, 1998

I-692, the Washington State Medical Use of Marijuana Act, passes with 59%.

After I-692

December 3, 1998

I-692 takes effect.

February 3, 1999

SB 5704 introduced to require DOH to adopt rules to implement RCW 69.51A. The bill fails.

February 8, 1999

SB 5771 filed to restrict I-692, goes nowhere.

November 5, 1999

State approves first qualifying condition petition, filed by I-692 sponsor Dr. Rob Killian, to add Crohn’s Disease.

January 28, 2000

State approves qualifying condition petition from Jon-Royal Fleming to add Hepatitis C.

April 9, 2000

Reasonable People’s Campaign files I-739 to remove criminal penalties for cannabis. Refiled as I-746 on May 19, 2000. The group challenged the state’s paper size requirements, and distributed 8.5x11” petitions via the Internet, but failed to make the ballot.

June 19, 2000

State partially approves qualifying condition petition from Dr. Rob Killian, adds “any disease, including anorexia, which result in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, and/or spasticity.” Insomnia and Post Traumatic Stress Disorder are denied

November 22, 2000

State denies qualifying condition petition from Robbie Robinson to add manic or chronic depression.

January 15, 2001

SB 5176 introduced by Sen. Jeanne Kohl-Welles to require DOH to implement rules to define a “presumptive sixty-day supply” of cannabis. Bill dies the following year.

March 12, 2002

Washington Court of Appeals rules in State v. Shepherd, upholds conviction of medical cannabis patient Ocean Israel Shepherd because his authorization stated that the medical use of cannabis “may” benefit him, not that it “would likely” benefit him, as the law states literally.

October 29, 2002

Federal Appeals Court rules that physicians have a first amendment right to discuss cannabis with their patients, and the DEA may not threaten to revoke licenses of authorizing physicians.

February 24, 2003

SB 5947 introduced to direct DOH to implement medical cannabis rules. Replaced by a bill to create a task force to study the issue, the bill dies in committee.

September 16, 2003

Seattle voters pass I-75, making cannabis the city's lowest law enforcement priority.

January 12, 2004

Sharon Tracy convicted on possession and manufacturing charges after court refuses to acknowledge her California medical cannabis authorization.

January 15, 2004

Monica Ginn found guilty of two charges after contacting Thurston County Sheriff to inspect her medical cannabis grow. The court refuses to allow her to raise a medical cannabis defense, and Ginn is sentenced to 36 months detention.

March 20, 2004

The first medical cannabis clinic, The Hemp and Cannabis Foundation starts writing medical cannabis authorizations in Washington State.

March 26, 2004

SB 5947 to define a 60-day supply of medical cannabis dies in Senate.

November 19, 2004

State denies qualifying condition petition from Glenn True to add depression and severe anxiety.

February 16, 2005

SB 5943 filed to make clear that patients have a right to raise an affirmative defense at trial, and to make clear what language an authorization must have on it. The bill carries on through 2006, and fails.

June 6, 2005

U.S. Supreme Court rules in *Gonzales v. Raich* that the federal government can prosecute medical cannabis patients who grow their own medicine in a state with a medical cannabis law.

August 9, 2005

Washington Court of Appeals reverses *State v. Ginn*, allows Monica Ginn to raise a medical cannabis affirmative defense.

January 11, 2006

SJM 8028 filed to request the federal Congress allow states to decide the medical cannabis issue, ultimately dies.

November 22, 2006

WA Supreme Court rejects 6-3 an appeal by Sharon Tracy, upholds ruling that out-of-state authorizations are not valid in WA.

May 1, 2007

Washington Court of Appeals reverses *State v. Hanson*, rules that a medical cannabis authorization obtained one day after a police raid is admissible in court.

May 8, 2007

SB 6032 signed into law, takes effect July 22, 2007. The bill makes clear that an authorization can state a patient “may” benefit from cannabis, not that they “would likely” benefit -- a response to the Shepherd ruling. It changes “primary caregiver” to “designated provider” to make clear this person need not be responsible for the “housing, health or care” of the medical cannabis patient they serve, responding to a second court ruling. It directs the Department of Health to define a “presumptive 60-day supply” of medical cannabis.

September 4, 2007

US District Court quashes Grand Jury subpoena for records about 17 medical cannabis patients authorized through The Hemp and Cannabis Foundation.

July 3, 2008

Cannabis Defense Coalition founded to track medical cannabis court cases.

November 2, 2008

Washington Department of Health medical cannabis rules take effect: a “presumptive” 60-day supply of medical cannabis is now 15 plants, 24 ounces.

March 24, 2009

A jury acquits Bruce Olson of cannabis manufacturing charges after a lengthy, expensive criminal trial. Kitsap County, considered one of the worst medical cannabis jurisdictions, immediately drops two more medical cannabis cases.

August 11, 2009

In State v. Otis, Court of Appeals reverses conviction of Earl Otis who was disallowed from presenting a medical cannabis defense.

January 11, 2010

Five local activists file Initiative 1068 to legalize cannabis, calling it the Sensible Washington campaign.

January 21, 2010

Washington State Supreme Court upholds conviction of medical cannabis patient Jason Fry, rules his medical cannabis authorization inadmissible because it was for a condition they ruled was not qualifying. Also rules that a medical cannabis authorization does not prohibit a search, and indeed is supporting evidence to justify a search.

February 2, 2010

State denies qualifying condition petition by Alex Chang to add bipolar disorder, severe depression, and anxiety-related disorders.

April 1, 2010

SB 5798 signed into law, expanding who can authorize the medical use of cannabis

July 1, 2010

Sensible Washington announces it did not qualify I-1068 for the ballot.

August 26, 2010

State approves qualifying condition petition by Ken Lachmann to add chronic renal failure, denies petition by Cannabis Defense Coalition to add “neuropathic pain” and denies petition by Kemp LaMunyon to add Alzheimer’s Disease.

September 29, 2010

Cannabis Defense Coalition files first-ever lawsuits against DOH over qualifying condition petitions, loses on neuropathic pain petition, strikes language DOH added to chronic renal failure petition.

October 15, 2010

Tacoma sends cease and desist letters to eight medical cannabis access points.

March 4, 2011

Sensible Washington re-files initiative to legalize cannabis, I-1149.

April 28, 2011

Federal agents aided by local police execute raids against Spokane access points.

April 29, 2011

Governor Gregoire vetoes much of SB 5073, leading to numerous impossibilities and obsolete references in the law, and outlawing the legal model underpinning most access points.

May 3, 2011

Three activist groups and two dozen individuals file petition to remove cannabis from the state's Schedule I drug list.

May 10, 2011

SB 5955 is introduced in the special session to address the veto. Opposed by many in the medical cannabis community, it fails.

May 18, 2011

Federal agents aided by local police execute raids against most remaining Spokane access points.

June 8, 2011

Sensible Washington announces it did not qualify I-1149 for the ballot.

June 9, 2011

WA Supreme Court rules in *Roe v. TeleTech* that "MUMA does not prohibit an employer from discharging an employee for medical marijuana use."

July 22, 2011

Non-vetoed portions of SB 5073 take effect.

November 8, 2011

Tacoma voters pass Initiative 1, making cannabis the city's lowest law enforcement priority.

November 15, 2011

Federal agents, aided by local police in all but Seattle, execute raids against access points in Lacey, Olympia, Puyallup, Rochester and Seattle.

November 30, 2011

Governor Chris Gregoire files petition with DEA to reclassify cannabis as a Schedule II drug.

January 27, 2012

Initiative 502 to restructure cannabis law in Washington State qualifies for November ballot after submitting 341,000 signatures.

February 14, 2012

SB 6265 dies in the Senate. The bill would have legalized access points in some jurisdictions, while clearly outlawing them in others.

March 15, 2012

Bellingham police raid three medical cannabis access points after the city revoked their business licenses and threatened to raid them.

REPORT MEDICAL CANNABIS ARRESTS

888-208-5332

**WASHINGTON STATE POTLINE
CANNABIS DEFENSE COALITION, WWW.CDC.COOP**

Legal Overview

Qualifying conditions

RCW 69.51A.010 defines “terminal or debilitating medical conditions” to include:

- (a) Cancer, human immunodeficiency virus (HIV), multiple sclerosis, epilepsy or other seizure disorder, or spasticity disorders;
- (b) Intractable pain, limited for the purpose of this chapter to mean pain unrelieved by standard medical treatments and medications;
- (c) Glaucoma;
- (d) Crohn’s disease;
- (e) Hepatitis C;
- (f) Diseases, including anorexia, which result in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, or spasticity; or
- (g) Any other medical condition duly approved by the Washington state medical quality assurance commission in consultation with the board of osteopathic medicine and surgery as directed in this chapter.

Additionally, the Medical Quality Assurance Commission approved the following condition in 2010:

- Chronic renal failure.

Source: RCW 69.51A.010(6), MQAC.

Cannabis limits

The standard answer to “how much cannabis may one possess?” is 15 plants, 24 ounces -- double that if one is both an authorized patient and a designated provider. This answer may not be entirely accurate after the 2011 legislative changes.

The original law passed by the people allowed patients a “60-day supply” of medical cannabis. What that meant was unclear and the issue arose frequently in court where the state argued that patients had too much medical cannabis for their needs and were thus drug dealers.

In 2007, the legislature directed the Department of Health to define a “presumptive” 60-day supply. Ultimately, the rule set 15 plants and 24 ounces of dried cannabis as the “presumptive” limit. One was still allowed a 60-day supply, even if that was above the presumptive limit.

In 2011, a sectional veto by Governor Gregoire left the law incongruous, some sections relying upon other sections which had been completely deleted. The original “60-day supply” affirmative defense section was deleted and replaced by three distinct affirmative defense clauses.

Section 043 can only be claimed with 15 plants or less (30 if one is a patient and provider). Section 045 may be claimed by patients or providers with more than the 15- or 30-plant limit. Any number of plants is acceptable so long as one can prove at trial that one’s necessary medical use exceeds the 15 plant limit. Section 047 has no codified plant limits and may be claimed by any

patient or provider who does not show an authorization to law enforcement upon questioning.

The collective garden section -- RCW 69.51A.085 -- allows for up to 45 plants between 3-10 patients. Nothing in law says two or more collective gardens may not occupy the same space, so it may be possible for collective garden participants to successfully raise an affirmative defense for more than 45 plants.

Thus, the answer is 15 plants and 24 ounces, 30+48 if one is a patient and designated provider, 45+72 if a collective garden, any amount one can prove at trial was *necessary*, or any amount one can convince a jury was acceptable when multiple collective gardens share space or when the patient or provider does not show an authorization to law enforcement.

What is “useable cannabis”?

After the 2011 partial veto by Governor Gregoire, the Department of Health moved to repeal the administrative rules it had adopted to define a presumptive 60-day supply of medical cannabis, and which also defined “useable cannabis” as the dried leaves and flowers of the plant, specifically excluding stems, stalks, seeds and roots. The rulemaking was announced November 1, 2011, and it appears nobody in the medical cannabis community was notified of this, despite previous requests to be notified of such rulemaking.

On February 16, 2012, WAC 246-75 was repealed by DOH. The definition of “useable cannabis,” a term used eleven times in RCW 69.51A, is once again undefined. What now constitutes “useable cannabis” may be decided by the courts.

Parental rights

“A qualifying patient or designated provider may not have his or her parental rights or residential time with a child restricted solely due to his or her medical use of cannabis in compliance with the terms of this chapter absent written findings supported by evidence that such use has resulted in a long-term impairment that interferes with the performance of parenting functions as defined under RCW 26.09.004.”

Source: RCW 69.51A.120.

Organ transplant non-protection

The law was amended in 2011 to ostensibly protect patients seeking organ transplants. RCW 69.51A.110 states: “A qualifying patient’s medical use of cannabis as authorized by a health care professional may not be a sole disqualifying factor in determining the patient’s suitability for an organ transplant, unless it is shown that this use poses a significant risk of rejection or organ failure.” In reality, the reason medical cannabis patients are refused organ transplants is because the hospital claims the medical cannabis use “poses a significant risk of rejection or organ failure,” so this law only codifies an existing, unfortunate policy.

Employment discrimination

Medical cannabis patients may legally be fired simply for being medical cannabis patients. The Washington State Supreme Court held in *Roe v. TeleTech*: “MUMA does not prohibit an employer from discharging an employee for medical marijuana use.”

Source: Roe v. TeleTech.

Valid Documentation

Valid documentation includes:

- (a) A statement signed and dated by a qualifying patient's health care professional, written on tamper-resistant paper, which states that, in the health care professional's professional opinion, the patient may benefit from the medical use of marijuana; and
- (b) Proof of identity such as a Washington state driver's license or identicard, as defined in RCW 46.20.035.

Remember that one needs both a medical cannabis authorization and proof of identity to possess valid documentation.

Source: RCW 69.51A.010(7).

Proof of identity

A qualifying patient must be a Washington state resident at the time they were authorized to use medical cannabis. But they certainly don't need a state driver's license or identicard to qualify for the protection of our law. Under RCW 46.20.035, proof of identity is any of the following:

- (a) A valid or recently expired driver's license or instruction permit that includes the date of birth of the applicant;
- (b) A Washington state identicard or an identification card issued by another state;
- (c) An identification card issued by the United States, a state, or an agency

of either the United States or a state, of a kind commonly used to identify the members or employees of the government agency;

- (d) A military identification card;
- (e) A United States passport; or
- (f) An immigration and naturalization service form.

Source: RCW 46.20.035, RCW 69.51A.010(4)(c).

Legacy paperwork

With the 2010 legislative changes mandating authorizations be written on tamper-resistant paper and dated, the legislature added a section to ensure that past authorizations would remain valid. RCW 69.51A.090 states:

"The provisions of RCW 69.51A.010, relating to the definition of 'valid documentation,' apply prospectively only, not retroactively, and do not affect valid documentation obtained prior to June 10, 2010."

For the moment, at least, authorizations written prior to June 10, 2010 without an expiration date are "grandfathered in." It is likely in the patient's best interest to obtain an updated authorization to reduce inconvenience in obtaining medicine from access points, or when encountered by law enforcement unfamiliar with the law.

Source: RCW 69.51A.090.

Validating paperwork

Access points, collective gardens and designated providers may wish to take steps to validate a patient's medical cannabis authorization. The main reason for this is to ensure one is afforded the affirmative defense provided by RCW 69.51A. If these entities serve patients with invalid authorizations, they will likely be unsuccessful in raising an affirmative defense to cannabis charges.

Authorizations may be invalid for several reasons, including:

1. It is not on tamper-resistant paper if signed after June 10, 2010;
2. The expiration date is past;
3. The health care professional was not properly licensed at the time of signature;
4. Verbiage required by RCW 69.51A.010(7) is not present; or
5. It is a forgery.

An access point or collective garden may wish to maintain a record of how it validates paperwork for potential members. The following is a suggested procedure:

Verifying authorizations

1. Verify that the authorization is signed and dated.
2. Verify that the authorization is on tamper-resistant paper if signed after June 10, 2010.
3. Verify that any expiration date has not passed.

4. Verify that the health care professional was licensed in Washington State at the time of signature. <http://fortress.wa.gov/doh/providercredentialsearch/>
5. Verify that the authorization includes language indicating the patient “has been advised by that health care professional about the risks and benefits of the medical use of marijuana.”
6. Verify that the authorization includes language indicating that the patient “has been advised by that health care professional that they may benefit from the medical use of marijuana.”

Verifying identity

1. Verify that the patient has proof of identity as defined in RCW 46.20.035.
2. Verify that the name on the proof of identity matches the name on the medical cannabis authorization.
3. Verify that the photograph on the proof of identity matches the patient.
4. Verify that the physical characteristics listed on the proof of identity match (height, weight, hair and eye color, etc.).

Calling health care professionals

The original method of validating patient authorizations was to call the doctor and ask if they signed the paperwork. The reasons for this were twofold: to “weed out” undercover informants and police, and to prove some level of due diligence. The main reason, however, was to filter out undercovers, according to Ric Smith, who spent many years doing this task at the original Green

Cross Patient Cooperative. In those days, non-medical cannabis users were not going to great lengths to join the cancer and AIDS patients over at the Green Cross -- it was the police who were forging medical cannabis authorizations, and it was for this reason that the Green Cross called the authorizing doctor.

In 2011, after federally-coordinated raids struck three Western Washington counties, it was discovered that undercover law enforcement were obtaining valid medical cannabis authorizations and visiting access points -- all of which engage in illegal activity under state and federal law -- to procure medical cannabis as part of law enforcement investigations. What this means is that the primary reason for which access points have historically called the authorizing health care professional is no longer served by taking such action. If a health care professional validates the authorization, that has no bearing on whether or not the patient is an undercover cop or informant.

Thus the only reason to contact the authorizing health care professional is to provide a sense of due diligence, or to prove it in court. This step is not required to prove due diligence in court, however. Furthermore, while validating patients may be routine business for some health care professionals, especially specialized medical cannabis clinics, many health care professionals do not want the burden of having to confirm a signature to every access point visited by a particular patient.

By signing a medical cannabis authorization, health care professionals have “done their part” -- they have fulfilled their duties under the medical cannabis law. Verbally validating authorizations to access points is a task not required of them by law, and one with which we prefer to not burden them.

Undated legacy paperwork

Technically, a handful of legitimate authorizations may exist that were signed before June 10, 2010, which do not have an expiration date, and which also do not have a date on which the doctor signed the authorization. The original law did not require the signature be dated, and while the overwhelming majority were dated, some were not.

While these may be legitimate, a basic concern arises: how does one know it is from before June 10, 2010, if the signature is not dated? If prosecuted, one can refer to chart notes from a doctor's files. But if a patient is trying to obtain medicine at an access point, they will encounter a basic conflict with the access point's legitimate desire to protect its affirmative defense to the best of its ability. This most likely means that they will not accept authorizations with undated signatures and no expiration date, which is likely a wise policy for them to maintain.

Health Care Professionals

Who may authorize?

- Physicians (18.71 RCW)
- Physician assistants (18.71A RCW)
- Osteopathic physicians (18.57 RCW)
- Osteopathic physicians' assistants (18.57A RCW)
- Naturopaths (18.36A RCW)
- Advanced registered nurse practitioners (18.79 RCW)

Source: RCW 69.51A.010(2)

Original protections

The following are not crimes or unprofessional conduct under Washington State law:

- (a) Advising a patient about the risks and benefits of medical use of cannabis or that the patient may benefit from the medical use of cannabis; or
- (b) Providing a patient meeting the criteria established under RCW 69.51A.010(26)* with valid documentation, based upon the health care professional's assessment of the patient's medical history and current medical condition, where such use is within a professional standard of care or in the individual health care professional's medical judgment.

** RCW 69.51A.010(26) does not exist; it is a reference to the definition of "qualifying patient."*

Source: RCW 69.51A.030(1)

Federal free speech protection

Health care professionals are protected under federal law by the *Conant v. Walters* ruling, in which the Ninth Circuit Court of Appeals ruled that the federal government may not threaten to revoke prescription licenses or initiate investigations into doctors who authorize the medical use of cannabis.

New requirements

In 2011, the legislature added several requirements for health care professionals who authorize the medical use of cannabis. A health care professional may only provide a patient with valid documentation after:

- (i) Completing a physical examination of the patient as appropriate, based on the patient's condition and age;
- (ii) Documenting the terminal or debilitating medical condition of the patient in the patient's medical record and that the patient may benefit from treatment of this condition or its symptoms with medical use of cannabis;
- (iii) Informing the patient of other options for treating the terminal or debilitating medical condition; and
- (iv) Documenting other measures attempted to treat the terminal or debilitating medical condition that do not involve the medical use of cannabis.

Source: RCW 69.51A.030(2)(a)

New prohibitions

A health care professional shall not:

- (i) Accept, solicit, or offer any form of pecuniary remuneration from or to a *licensed* dispenser, *licensed* producer, or *licensed* processor of cannabis products;
- (ii) Offer a discount or any other thing of value to a qualifying patient who is a customer of, or agrees to be a customer of, a particular *licensed* dispenser, *licensed* producer, or *licensed* processor of cannabis products;
- (iii) Examine or offer to examine a patient for purposes of diagnosing a terminal or debilitating medical condition at a location where cannabis is produced, processed, or dispensed;
- (iv) Have a business or practice which consists *solely* of authorizing the medical use of cannabis;
- (v) Include any statement or reference, visual or otherwise, on the medical use of cannabis in any advertisement for his or her business or practice; or
- (vi) Hold an economic interest in an enterprise that produces, processes, or dispenses cannabis if the health care professional authorizes the medical use of cannabis.

Source: RCW 69.51A.030(2)(b)

Authorize, not prescribe

It is important to understand that one may not *prescribe* medical cannabis. The word *prescribe* is a federally-regulated word, and to prescribe cannabis would be illegal under federal law. One may *authorize* the use of medical cannabis, not *prescribe* it. Avoid writing cannabis authorizations on official prescription pads.

Tamper-resistant paper

That said, all new medical cannabis authorizations must be printed on so-called “tamper resistant paper,” which has one or more features designed to prevent copying, counterfeiting, or modification of data. This is commonly called security paper. It is the same paper on which all prescriptions in Washington State must now be written.

Patients require many copies of this authorization on tamper-resistant paper. Health care professionals are encouraged to provide these at minimal, if any, cost.

Authorization verbiage

The Washington State Medical Association provides recommended copy for medical cannabis authorizations. For many years this has been the “most trusted” verbiage:

http://www.wsma.org/files/Downloads/PracticeResourceCenter/Med_Mari_authorization.pdf

Qualifying Patients

Affirmative defense

It is important to understand that medical cannabis remains illegal in Washington State. Patients and designated providers may raise an “affirmative defense” to cannabis related charges in front of a jury, if a judge does not grant a pre-trial motion from the prosecutor to forbid the patient from even mentioning our medical cannabis law to the jury. This means police may detain, search, seize and arrest a medical cannabis patient and “send them through the wringer,” all the while knowing the patient has a legal defense to cannabis related charges.

Law enforcement regularly use the “process” as the punishment. Patients are encouraged to seek comfort in their authorization to use medical cannabis, but do not make the core mistake of thinking one is a *legal* medical cannabis patient.

Show paperwork or shut up?

For some years, based on Washington state law and court rulings, medical cannabis advocates have advised patients to show their medical cannabis authorization when law enforcement inquire about their cannabis use. With the legislative changes of 2011, the law now has three distinct affirmative defense clauses.

Two of the three say nothing about showing paperwork to law enforcement upon questioning, and one of them, RCW 69.51A.047, specifically applies to an authorized patient or designated provider who “is not registered with the registry established in section 901 of this act or does

not present his or her valid documentation to a peace officer who questions the patient or provider regarding his or her medical use of cannabis ...”

It would seem the law no longer requires patients to present valid documentation to law enforcement upon questioning. Whether or not they present valid documentation, a patient can be arrested if the officer discovers they possess medical cannabis. And thanks to a recent Supreme Court ruling *Kentucky v. King (2011)*, an officer’s claim that they smell cannabis is enough to justify a search.

In some cases, patients who provide valid documentation to police are let go without incident. In more and more cases, police decline to arrest, but seize all of the patient’s medical cannabis, and inform them to expect a court summons in the mail.

How to obtain medical cannabis

While patients should feel no moral quandary obtaining cannabis from the so-called “black market,” our medical cannabis law provides three ways for a patient to obtain medical cannabis:

1. Grow it themselves;
2. Designate another person to grow for them; or
3. Join a “collective garden.”

See sections “Growers,” “Designated Providers,” and “Collective Gardens” for more info.

Access points

Medical cannabis access points existed before the citizens of Washington State enacted a medical cannabis law in 1998, they have existed since then, and they have increased in number and grown more public in recent years.

Access points are necessary components of a system to provide medical cannabis to qualifying patients. They also may operate in a “grey area” of the law.

While an access point’s compliance with the law is technically important, on a practical level, evaluating an access point boils down to personal preference. Is the place clean enough? Are the people nice enough? Are they knowledgeable about cannabinoid medicine and the cannabis plant?

Forms of access points

Designated provider: The original language of I-692 allowed a patient to designate one other person to produce medical cannabis on their behalf.

Physical locations: A physical “brick and mortar” store typically comes to mind when people think of access points.

Home delivery services: These may actually be serving more patients than their physical counterparts. After federal raids in 2011, most access points in Eastern Washington are delivery services.

Patient to patient: Many patients obtain cannabis directly from other patients who are “in the same boat” as them.

Farmers’ markets: In the past few years, a number of entrepreneurs have set up semi-public markets to connect growers with the end patient.

Collective gardens: Codifying into law the “group grows” representing many patients, this new form of access point has become the new legal footing for most other access point methods.

Non-medical cannabis market: The traditional street dealer is still used by patients unable to find other forms of access points, or who choose to use them for other reasons (level of comfort, quality, existing relationship, etc).

Product overview

Medical cannabis patients can expect to encounter cannabis in many forms, which frequently have distinct properties, effects, methods of consumption, etc.

Unprocessed cannabis:

Flowers: These “buds” are most often what people refer to when they use the words cannabis or marijuana. May be smoked, vaporized, used directly in food and cooking, or processed into other products.

Leaves: Often called “shake,” high quality “sugar leaf” is often smoked, vaporized or processed into other products.

Stems: Frequently disposed of as trash, stems can be brewed into tea, or used to produce other products.

Root mass: Soap and other products can be produced from so-called “root balls.”

Processed cannabis:

Concentrates: Kief is made by agitating dry cannabis over a screen and catching the cannabinoid-rich trichomes which fall through. Kief is also called hash, and typically pressed. Hash may also be extracted the same way as kief but in ice water; this is called ice water hash, or “bubble hash.” Hash may also be collected from hands or trimming scissors and are typically called finger hash and scissor hash, respectively. Hash oil, or honey oil, most often refers to solvent extractions of cannabis -- usually butane, but maybe isopropyl alcohol, ethanol, naphtha, glycerin, supercritical CO₂ or other solvents. Some people call this “Rick Simpson oil” after an activist who believes topical and ingested hash oil cures many ailments.

Edibles: When used in food, cannabis is most often extracted into butter, olive oil, coconut oil, or another fat -- cannabinoids are fat soluble. From these base fats can be made any food, or the fats can be processed into pills. Cannabis concentrates may also be used to create food products. Cannabis flowers and leaves may be ground into “cannafLOUR.” Fresh cannabis leaves, buds or entire plants may be juiced. In reality, most medical cannabis edibles that patients will encounter in access points are desserts.

Tinctures: Most often extracted using strong alcohol or vegetable glycerin, tinctures are typically ingested orally by dropper, diluted in other liquids, or applied topically in some cases.

Topicals: Salves, balms, creams and lotions are meant for topical skin applications.

Hygiene: Soaps, shampoos, toothpastes, dental floss and the like are becoming more readily available.

Pricing

Prices for medical cannabis may vary wildly, even for comparable samples. One may obtain low quality cannabis flowers for as low as \$4/gram or less. As of this writing, one may obtain quality cannabis flowers for around \$10/gram, with prices up to \$15/gram or more.

Concentrates usually cost more than unprocessed flowers. Prices reflect a number of factors including perceived quality and availability, and high quality or hard-to-obtain samples may command much more than these ranges. One may obtain dry-screened kief for \$5-25 per gram. Water hash can be had for around \$10-50 per gram or more. Hash oil can be had for around \$20-80 per gram or more.

The cost of edibles can vary greatly depending on the type of food product and the ingredients. A common brownie, cookie or similar product might cost from \$2-8 depending on size and dosage.

Tinctures range from \$10-40 per fluid ounce or more. Topicals and hygiene products, some of them entirely new to the market, vary wildly in price.

Basics of cannabinoid medicine

The “endogenous cannabinoid system” is a group of compounds and receptors in the human body that are involved in a variety of physiological phenomena including appetite, pain sensation, mood and memory. To date, research has discovered two known cannabinoid receptors, called CB1 and CB2, that are expressed predominantly in the nervous system and the immune system, respectively.

Molecules that can connect to these receptors -- by virtue of their structural shape -- are called cannabinoids. The human body naturally creates its own cannabinoids -- the first, anandamide, was discovered in 1992, and four others have been discovered since then. The cannabis plant produces at least 85 known cannabinoid compounds. A very few other plants -- notably echinacea -- are known to produce compounds that can bind to CB1 and CB2 receptors. Cannabinoid compounds may also be synthesized using chemistry.

Nothing in the natural world produces cannabinoid compounds in such abundance and variety as the cannabis plant. They are found in greatest concentration in the flowers -- the source of seeds and offspring -- suggesting they play some role in helping the species survive or spread. It may be that they provide some protection against bacteria, fungi or ultraviolet light. Some cannabinoids are psychoactive to many animals, causing most predators to avoid eating the plant -- except for human beings, who began cultivating and breeding the plant in search of greater euphoric and medicinal qualities.

Different cannabinoids have distinct effects in the human body. Delta-9-Tetrahydrocannabinol, or THC, is the main psychoactive compound and one of the most abundant cannabinoids in the cannabis plant -- likely due to millennia of human selection for psychoactivity. Other cannabinoids are minimally- or non-psychoactive and may play roles in modulating inflammation, pain, anxiety, nausea, convulsion and other physiological phenomena.

Put simply, cannabinoids effect a wide range of symptoms. Each one of the 85+ discovered to date in the cannabis plant may provide distinct and different benefits. Some of them act synergistically, causing others

to have greater effect in their given area. Generally speaking, cannabis is best thought of as a "whole plant medicine" wherein the plant-form with its unique fingerprint of medicinal compounds is more beneficial than any one isolated compound.

Cannabis consumer safety

Cannabis is one of the safest medicines in our modern pharmacopeia, but it is by no means without negative effects. Some users may not appreciate the altered consciousness -- the mental "high" -- that often accompanies cannabis consumption. Feelings of discomfort, anxiety, restlessness or even panic are possible, and breathing, heart rate and blood pressure may change. New patients are advised to "ease into" medical cannabis to get a feeling for the sensory and mood changes they experience.

While smoking is a common form of cannabis ingestion, vaporization is widely considered a much healthier alternative to combusting cannabis. Vaporizers heat the plant material to a temperature where cannabinoids evaporate into the air without combustion. Studies show that vaporizers can significantly reduce smoke toxins.

Cannabis culture tends to be a social culture, and cannabis users may pass pipes or joints or dangerously-hot paraphernalia to each other like it's an everyday affair. Be aware that placing in one's mouth objects that have been in the mouths of others is akin to kissing that person on the mouth. The best protection against communicable diseases is abstinence -- not sucking on the joint or whatever object one may feel naturally inclined to place in one's mouth because others are doing so with such seeming comfort.

Designated Providers

Legal definition

“Designated provider” means a person who:

- (a) Is eighteen years of age or older;
- (b) Has been designated in writing by a patient to serve as a designated provider under this chapter;
- (c) Is prohibited from consuming marijuana obtained for the personal, medical use of the patient for whom the individual is acting as designated provider; and
- (d) Is the designated provider to only one patient at any one time.

Source: RCW 69.51A.010.

Fifteen-day clause

With the 2011 legislative changes, a section of law was added to disallow designated providers from serving more than one patient in a 15 day period. Medical cannabis access points had been operating as designated providers to numerous patients on a “one at a time” basis, which satisfied the legal requirements of the law. RCW 69.51A.100 was added to disallow this legal defense to access points.

- (1) A qualifying patient may revoke his or her designation of a specific provider and designate a different provider at any time. A revocation of designation must be in writing, signed and dated. The protections of this chapter cease to apply to a person who has served as

a designated provider to a qualifying patient seventy-two hours after receipt of that patient’s revocation of his or her designation.

- (2) A person may stop serving as a designated provider to a given qualifying patient at any time. However, that person may not begin serving as a designated provider to a different qualifying patient until fifteen days have elapsed from the date the last qualifying patient designated him or her to serve as a provider.

Source: RCW 69.51A.100.

Understand the basics

Designated providers are encouraged to read through everything in the *Authorized Patients* section, which applies equally in almost all cases to designated providers.

It is important to understand the legal nature of the affirmative defense provided by the law, and to consider how one might best react when confronted by law enforcement authorities. For those growing medical cannabis, see also the *Growers* section.

Collective gardens off limits?

In many if not most situations, a designated provider is growing medical cannabis for an authorized patient. In some situations, a designated provider only acquires medical cannabis for the patient. May a patient send a designated provider to pick up medicine from a collective garden?

The answer seems to be no. The collective garden language mentions only qualifying patients, completely omitting designated providers. It also requires that “[n]o useable cannabis from the collective garden is delivered to anyone other than one of the qualifying patients participating in the collective garden.”

Source: 69.51A.085.

Necessary paperwork

Written designation: A designated provider must have a written statement from a qualifying patient memorializing them as the patient’s designated provider. With the partial veto of 2011, the law does not clearly state that a designated provider must have the patient’s valid documentation, but it was necessary before and it is recommended.

Valid documentation: The qualifying patient’s valid documentation includes the medical cannabis authorization, written on tamper-resistant paper, and proof of identity. It is unclear whether a copy of the authorization will suffice -- the law simply says “valid documentation” must be on tamper-resistant paper. We recommend keeping an original tamper-resistant authorization on hand, with a copy of the patient’s proof of identity. Technically, a copy of an ID is not proof of identity, but it is unreasonable to require a designated provider to hold onto original ID for a qualifying patient.

Cannabis limits

The short answer: 15 plants and 24 ounces, twice that if both a patient and provider. For a more in-depth answer, see “Cannabis limits” in the *Legal Overview* section.



Join the Coalition!

Cannabis Defense Coalition is a nonprofit, nonpartisan cannabis activism organization. A member cooperative based on the principle of “one member, one vote,” CDC identifies and implements small-scale projects in support of Washington State cannabis policy reform. To join, send \$40 and the form below to CDC, PO Box 45622, Seattle, WA 98145 or pay online at www.cdc.coop. We would be honored to earn your support.

Name _____

Address _____

City _____ State _____ Zip _____

Email _____

Phone _____

Please make checks payable to “Cannabis Defense Coalition.”



Collective Gardens

Rules

Qualifying patients may create and participate in collective gardens for the purpose of producing, processing, transporting, and delivering cannabis for medical use subject to the following conditions:

- (a) No more than **10 patients**;
- (b) No more than **15 plants per patient** up to a total of 45 plants;
- (c) No more than **24 ounces of useable cannabis per patient** up to a total of 72 ounces of useable cannabis;
- (d) A copy of each qualifying patient's **valid documentation** -- including a copy of the patient's ID.
- (e) No useable cannabis from the collective garden is delivered to anyone other than one of the qualifying patients participating in the collective garden.

Source: RCW 69.51A.085.

Collective garden defined

The creation of a “collective garden” means qualifying patients sharing responsibility for acquiring and supplying the resources required to produce and process cannabis for medical use such as, for example, a location for a collective garden; equipment, supplies, and labor necessary to plant, grow, and harvest cannabis; cannabis plants, seeds, and cuttings; and equipment, supplies, and

labor necessary for proper construction, plumbing, wiring, and ventilation of a garden of cannabis plants.

Source: RCW 69.51A.085(2).

Most parolees barred

In 2011, the law enforcement lobby asked for, and received, language allowing them authority to disallow many parolees from using medical cannabis.

“The provisions of RCW 69.51A.040, **69.51A.085**, and 69.51A.025 do not apply to a person who is supervised for a criminal conviction by a corrections agency or department, including local governments or jails, that has determined that the terms of this chapter are inconsistent with and contrary to his or her supervision.”

This means that a patient who is under supervision, **and** is required by the court to pass a drug test, **and** has no court-ordered exemption for medical cannabis, may not participate as a qualifying patient in a collective garden.

Source: RCW 69.51A.055(2).

Growers

Who may claim an affirmative defense to cannabis charges?

Cannabis growers are afforded the protection of our law as either authorized patients or designated providers. Nobody else is explicitly protected for producing cannabis. RCW 69.51A.050 protects people against prosecution for “constructive possession, conspiracy, or any other criminal charge solely for being in the presence or vicinity of medical marijuana.” Watering a cannabis plant goes beyond “solely” being in the presence of cannabis, and unless one is a patient or designated provider, one may be vulnerable to successful prosecution.

The collective garden section authorizes patients to acquire labor necessary to produce medical cannabis, but it does not explicitly provide non-patient contractors or employees with an affirmative defense.

Valid documentation required

Anyone growing cannabis will require “valid documentation” to successfully raise an affirmative defense to cannabis-related charges. See the *Valid Documentation* section.

It is generally recommended to post valid documentation on site at a medical cannabis grow. Technically, nothing in law requires valid documentation be posted. It is considered useful to have valid documentation posted if law enforcement enter the premises when the responsible party is absent or otherwise indisposed.

As of 2011, the collective garden language

-- RCW 69.51A.085 -- mandates that “a copy of each qualifying patient’s valid documentation ... including a copy of the patient’s proof of identity, must be available at all times on the premises of the collective garden.”

Be responsible

The effects of a cannabis grow operation can be far reaching. Growers are responsible for overseeing the operation and ensuring that issues that arise are addressed before they become large problems.

Responsible growers will educate themselves about, and comply with, the laws governing medical cannabis in Washington State. Reading this guide is a good start.

Growers or their contractors are responsible for complying with any building and electrical codes governing their cultivation-related construction.

Growers are responsible for the quality of their finished product: whether it is clean and free of contaminants that may cause detrimental side effects to medical cannabis patients.

Types of contaminants

Pesticides and fungicides: Neem, sulphur, sodium bicarbonate, potassium bicarbonate, pyrethrum, Avid, Floramite, Eagle 20, other commercial pesticides and fungicides, etc.

Fungal: molds, mycelia, mildew, yeast.

Biological: Dead and living insects, insect eggs and webs, animal dander and feces, human hair and dander, smoke residue.

Environmental: Soil, perlite, other growing media, nutrient residue, dust, fiberglass.

Other: Bulb leakage, outgassing or explosion, toxic household cleaners and chemicals.

Environmental concerns

Environmental considerations related to cannabis cultivation may include energy use, growing methods, types of fertilizer and growing medium, and the reusing, repurposing, recycling or disposal of used products, equipment and waste.

Light bulbs. Fluorescent bulbs, including the metal halide and high pressure sodium bulbs used by most cannabis growers, contain mercury. It is illegal to dispose of these in the garbage -- legally they must be recycled. Beyond that, responsible cannabis producers have an ethical obligation to limit the amount of neurotoxic heavy metals they dump into shared water and air. The following businesses recycle bulbs:

- Ecolights Northwest, Seattle, 206-343-1247, www.ecolights.com.
- Kelsun Distributors, Bellevue, 425-453-1199, www.kelsun.com. \$1.75 ea.
- Indoor Sun Shoppe, Seattle, 206-634-3727, www.indoorsun.com. Free if buying replacement bulb, \$4 for 1000w, \$2 for 400w or 600w.
- Waste Management, 800-664-1434, www.wmlamptracker.com

Soil. In a perfect world, soil would be reused -- it may be sterilized using heat, if that is a concern. Soil can be used for outdoor gardening and landscaping, and when one's

yard is filled with perlite-rich soil, one can find a friend who needs gardening soil. In Seattle, bulk soil may not go in the yard waste and compost -- officially, soil goes in the garbage. Pacific Topsoils (206-418-1301) recycles soil for \$26 per cubic yard.

Expired and waste nutrients. The transfer station will take up to 50 gallons of "hazardous materials."

Charcoal filters. Limited amounts of charcoal can be used as a soil amendment in home gardening or landscaping. The metal filter housing can be recycled or given to metal scrappers.

Stems, stalks and root mass. Plant matter can be made into products, composted at home, or placed in one's food and yard waste -- which may be a security concern.

Transportation. Local products typically have a smaller environmental footprint.

Security

Growers also bear a responsibility to provide a reasonable level of security to protect family, friends and neighbors from harm. Most growers begin this process in their own home with limited resources. Security is always important, but does not necessarily equal expensive measures. Often, the most effective security is discretion -- "loose lips sink ships." Be a good neighbor.

While the right to bear arms is guaranteed by the U.S. Constitution, be aware that federal or state sentencing enhancements may add mandatory additional imprisonment for possessing a firearm during the commission of a drug-related offense. See "School zone and gun enhancements" in the *State Cannabis Penalties* section.

Processors

Extractions

In discussing processors, we are primarily referring to those who make or further process extractions of cannabis. In a very few instances, processors are not making or using cannabis extractions -- trimming and cannafLOUR production are two examples. Extractions -- typically hash, hash oil, butter or cooking oils -- may be used in their “raw” form or further processed into foods, beverages, creams, salves, tinctures, etc.

Cannabis for extraction is ideally free of mold, fungus, and pesticides. Extracting processes can concentrate both contaminants and their by-products. End products reflect the quality of the starting material.

Processors may wish to consider the “dietary supplements” guidelines published by the Food and Drug Administration (FDA). While not specific to medical cannabis, they do provide guidance to processors of botanical medicines.

<http://www.fda.gov/Food/GuidanceComplianceRegulatoryInformation/GuidanceDocuments/SmallBusinessesSmallEntityComplianceGuides/ucm238182.htm>

Types of extractions

Extraction processes can be thought of in two ways. They are either solventless or solvent-based. Within these categories, extractions may be either be cold or hot. In the case of solventless extractions, they may also be defined as wet or dry.

Solventless extractions: Water hash, dry kiefing, finger hash, scissor hash, and non-solvent hash oil.

Solvent-based extractions: Butter, oils, other fats, glycerin, alcohols, butane, naphtha, CO₂, propane, hexane, and acetone.

(Note: this list may not be exhaustive. Also, many people disagree on the acceptability of many of these solvents in the production of medical cannabis extracts.)

Extraction risks

Two main categories of concern arise when considering risks associated with medical cannabis extractions. The first category is risk to the processor making the extraction. The second category is risk to the end patient who may consume that extracted product.

Solventless extractions generally have a lower risk associated with production than solvent-based extractions. Solventless extractions may retain more existing contaminants, but they typically do not introduce new contaminants as can occur in solvent-based processes.

Risks associated with solvent-based extractions include skin exposure, ingestion, inhalation of volatile (airborne at room temperature) solvents, fire and explosion.

Risks to the patient include impure starting solvents, which may have contaminants that may remain in the final extraction. The health effects of some of these contaminants may be debatable, but generally, it is in a patient’s best interest to have the least-contaminated

extractions possible.

In either solventless or solvent-based extractions, one of the largest concerns is concentrating contaminants from the source material. Contaminants like pesticides, mold and mildew may distill down in all extractions. Solvent-based extraction processes may kill live mold but actually condense their toxic byproducts.

Food processor requirements

Anyone handling unpackaged food products intended for public consumption is required to have a Washington State food handler's permit. This class will help food processors learn basic hygiene, safe food storage techniques and proper temperature control. Information regarding the Washington State food handler's permit is available at:

<http://www.doh.wa.gov/ehp/food/workercardfaq.html>

The Washington State Food Code, RCW 69.07, requires prepared food and food service items to be prepared in a Retail Food Service Establishment or a commercial kitchen. See the handout titled "Selling Prepared Foods" from the Washington State Department of Agriculture:

<http://agr.wa.gov/marketing/smallfarm/DOCS/9-SellingPreparedFoods.pdf>

Food processor's permit

According to the Washington State Department of Agriculture, one must have a Washington State Food Processor License if one does any of the following:

- Cook, bake, freeze, slice, dehydrate, smoke, roast coffee beans, bottle water or repackaging any type of food;
- Process/package food for someone else;
- Make shelf-stable, low acid canned food i.e.; canned vegetables, canned fish, bread or cake in a jar and chocolate sauce;
- Further process finished dairy products (i.e. cheese cutting, flavored dairy products, frozen ice cream desserts); or
- Process dietary or nutritional supplements that do not make health claims.

This is not an exhaustive list. Details about and application for a food processor's permit may be found at the Washington State Department of Agriculture's web site:

<http://agr.wa.gov/foodanimal/foodprocessors/>

Labeling

The FDA maintains general food labeling requirements. These can be found at:

<http://www.fda.gov/Food/GuidanceComplianceRegulatoryInformation/GuidanceDocuments/FoodLabelingNutrition/FoodLabelingGuide/ucm064866.htm>

Consider adding to the label the amount of useable cannabis represented by the food product. This will help access points and patients know how much cannabis product they may possess.

Access Points

Nomenclature

An *access point* is defined as a source from which a patient may obtain medical cannabis.

Over time, many terms have been applied to these locations, including dispensaries, cooperatives, collectives and compassion centers. Community members may argue over any one of these terms, but the term *access point* seems widely acceptable.

Obtain counsel

Access point operators are advised to consult with an attorney who is familiar with Washington State medical cannabis law. Make sure this attorney is aware of any county and city ordinances or moratoriums relating to medical cannabis.

Basic types of access points

At least seven distinct types of access points exist, but this section is focused on physical locations, delivery services, patient to patient transfer, and farmers' markets. For a more in-depth explanation of the types of access points, see "Types of Access Points" in the *Qualifying Patients* section.

Basic issues

I-692 was intentionally simple; it was feared that addressing details would give opponents and supporters alike fodder for criticism, leading to failure at the polls. One of the most glaring uncertainties was the amount

of cannabis one could possess. Initiative sponsors feared putting in any amount, so they allowed a "sixty-day supply."

Similarly, while access points existed before and during the campaign, initiative drafters feared such language would risk too many electoral points. The initiative allowed patients to produce and possess cannabis, and to designate one other person as a "primary caregiver" who could also produce and possess cannabis.

The most basic issue for any access point is this: *how to operate in a such a manner that one may be best situated to successfully raise the affirmative defense to cannabis charges provided by RCW 69.51A?*

This breaks down to a number of questions and concerns, but typically the main one is this: *how does the law allow an access point to serve multiple patients?*

The following sections will provide details on three models -- or legal theories -- under which access points have operated:

- Collectivized cost model
- Designated provider model
- Collective garden model

Collectivized cost model

One of the first legal theories supporting large access points was the collectivized cost model. Technically, this existed before I-692 passed, when only a common law

medical necessity defense could potentially save patients from a cannabis conviction. The basic theory is that if one patient may produce and possess medical cannabis, nothing in state law forbids two or more patients from doing so in the same space. Furthermore, nothing in state law prohibits them from sharing the costs associated with that production.

Thus, any number of patients may come together to share the burden of producing and accessing their medical cannabis. This can extend far beyond an actual grow room, to include the cost of a physical meeting space or access point, cost of labor to manage grow operations and the access point, legal costs for their prosecuted members, etc.

As with every model explained herein, this model does not provide protection from federal charges. It also may not provide protection against state charges for “constructively possessing” more cannabis than one patient may possess under state law. If a patient is arrested at a grow operation intended to produce enough medical cannabis to meet the needs of more than two patients, they are in constructive possession of more cannabis than state law allows, and they may be at risk for successful prosecution under this model.

Designated provider model

The original law allowed a primary caregiver -- later changed to designated provider -- to serve “one patient at any one time.” The phrase “at any one time” was interpreted by access points to mean they could be designated provider to one patient one minute, stop serving that patient, and become designated provider to another patient the next minute. Some access points actually had patients sign designated provider forms before each

transaction, and revocation forms after.

In 2011, the legislature added a clause that said designated providers had to wait 15 days from the designation date before they could serve another patient. The bill was intended to expressly legalize medical cannabis access points, but that portion was vetoed by Governor Chris Gregoire. The 15-day designated provider amendment -- the slight change which removed the legal footing on top of which most access points rested -- survived the partial veto. Thus, the designated provider model was effectively outlawed.

*RIP: Designated Provider Model
December 3, 1998 - July 21, 2011*

Collective garden model

As of July 22, 2011, most access points operate under some form of legal theory involving the collective garden language in RCW 69.51A.085.

In this model, the access point is a network of collective gardens that have production and processing tracked to ensure quality and legal compliance. Access points ensure that the delivery of any useable cannabis is only between a qualifying patient and the collective garden for which that patient is assigned. Patients can be assigned dynamically to collective gardens, and the patient may end association with a collective garden at any time. Access points and collective gardens are expected to comply with each statutory requirement of RCW 69.51A.085. See “Rules” in the *Collective Gardens* section.

In essence, the access point is managing the relationship between a patient and the patient’s collective gardens. A patient may

join any number of collective gardens, thus they can obtain medical cannabis from any number of different collective gardens represented by an access point. The purpose of the access point is to assist patients in identifying collective gardens that will best meet their individual needs, whether that is on the basis of availability, cost, quality, form, etc.

Such assistance consists of verifying qualifying patients wishing to participate in collective gardens (see “Validating Paperwork” in the *Valid Documentation* section), providing information regarding collective gardens, acquiring resources from participants required for the collective garden, and dynamically connecting the patient with a collective garden that will most effectively meet his or her medical needs.

All collective gardens must adhere to the limits as set forth in RCW 69.51A.085. No collective garden may contain more than 10 qualifying patients at any one time. Collective gardens may contain no more than 15 plants per patient and no more than a total of 45 plants. Collective gardens may contain no more than 24 dried ounces of useable cannabis per patient and no more than 72 ounces of useable cannabis at any one time. Nothing in RCW 69.51A prohibits more than one collective garden from occupying the same tax parcel. Thus, any number of collective gardens may be represented by a single access point.

No medical cannabis produced from a collective garden may be delivered to anyone other than a qualifying patient participating in that specific collective garden. (See “Collective gardens off limits?” in the *Designated Providers* section.) Patients verified through access points may participate in a collective garden of their choosing with the further understanding that:

Patients shall only participate in, and access useable cannabis from, the specific collective garden a patient is associated with;

Nothing prohibits a patient from terminating association with one collective garden to join another collective garden; and

The collective garden and/or access point shall have a copy of each qualifying patient’s valid documentation including a copy of the patient’s proof of identity, available at all times on the premises.

Patients within a collective garden may access their medicine through an access point depending on patient needs.

History of discretion

For over ten years, medical cannabis in Washington State was “on the down low” to a large extent -- about the only advertising one might have found were ads in the Little Nickel for THCF and a few other clinics that specialized in medical cannabis authorizations.

In 2010, this started to dramatically change. That year the Cannabis Defense Coalition hired a lobbyist solely to work on a medical cannabis bill -- a first in Washington State. Whereas only medical doctors and osteopathic doctors could authorize the medical use of cannabis before 2010, SB 5798 expanded that list to include naturopathic doctors, physician’s assistants, and advanced registered nurse practitioners. At every point, the bill, spearheaded by Senator Jeanne Kohl-Welles, cleared critical votes and deadlines at the last possible minute, and it was signed into law on April 1, 2010 -- April Fool’s Day.

We are extremely proud of this change --

before 2010 most doctors were afraid to sign medical cannabis authorizations -- but we do believe this was the change that triggered a “shift in discretion” in the medical cannabis industry. More medical cannabis authorization clinics opened, and, like any intelligent business, they began advertising. The front page of the Little Nickel became filled with medical cannabis ads -- large, graphical, eye catching ads designed to attract attention.

Likely because of the increased access to health care professionals able and willing to authorize the medical use of cannabis, more qualifying patients became authorized. And by Fall 2010, the number of physical access points had increased significantly, and not just in “pot-friendly” Seattle -- several had opened storefront shops in Tacoma and Spokane. What was once seen as a significant risk undertaken by only the most devout, prison-willing activists took on a rosier color to newly-authorized patients empowered by their affirmative defense, or more often a perception that their activities were “legal” under state law.

Access points started putting up signage indicating they were medical cannabis access points. They started advertising their addresses -- unheard of in the past -- on web sites like Weed Maps and Pot Locator, in the new “Green Providers” section of The Stranger, all over the front of the Little Nickel, and a number of “industry publications” that were sprouting up.

Such cultural change in such a short span of time caused a tangible backlash against the medical cannabis community. Many of the new restrictions placed on health care professionals in 2011 came suddenly from Senator Mike Carrell who passed out copies of the Little Nickel and quoted a “Cannaphath Medical” ad while arguing against medical

cannabis on the floor of the legislature. It appeared to anger him.

Despite supermajority support for medical cannabis -- the idea -- the notion of medical cannabis the storefront retail establishment raised the ire of some local governments and law enforcement agencies. Tacoma sent cease and desist letters to eight access points in October 2010. Underlying the letters was the threat of follow-up raids, which were staved off likely due to massive community reaction, protests, and an increased willingness on the part of access points faced with the threat of extinction to invest money into activism and politics.

In April 2011, federal law enforcement raided most physical access points in Spokane. The patient community immediately responded with protests during the raids. The image of patients demanding safe access to medical cannabis was juxtaposed with fifteen-foot pole signs advertising cannabis, and windows painted with “BUY - SELL - TRADE” and pot leaf imagery. These things may have offended Michael Ormsby, US Attorney for the district.

In November 2011, federal raids hit three counties in Western Washington, including the medical cannabis citadel of Seattle. While the raids in Thurston County seemed more general in who they targeted, the three access points raided in Seattle were some of the more overt, envelope-pushing in the medical cannabis industry. One was known for large advertisements featuring buxom models in nurse outfits and an “Uncle Sam” character informing growers the access point seeks to purchase cannabis.

Another made an intentional media splash about its envelope-pushing cannabis cafe in White Center, among other things. In our meetings during the 2011 lobby session,

one of the representatives from White Center -- herself an ardent supporter of medical cannabis -- said she wanted to make certain that any successful medical cannabis legislation made clear that such activity is illegal. She seemed concerned and reactive.

The point here is this: we do not exist in a vacuum. It is incumbent upon access points to observe the world around them -- to know the neighbors, the neighborhood, the gossip that goes 'round, how their advertising is perceived by others, etc. -- and to work to minimize one's negative impacts or perceived negative impacts on that world. *Know that your actions affect how members of the public view the medical cannabis issue and the medical cannabis industry.*

Access point considerations

Location. While no specific regulations currently exist in Washington State regarding access point locations, it may be worthwhile to remember two things. First, the federal "drug free schools" law encourages states to enact additional penalties for drug crimes committed within 1,000 feet of a "school zone." RCW 69.50.435 -- which does not apply to the "leaves and flowering tops of marihuana," but does seem to apply to other parts or extracts of the cannabis plant -- includes 1,000-feet from schools, school bus route stops, and civic centers designated as drug-free zones as "double-penalty" zones.

Second, recent legislative bills have included provisions to disallow medical cannabis access points within 500 feet of state-defined "school zones." Generally, it is good to be in a supportive neighborhood, wherever that may be. Engage the neighbors, help clean up the neighborhood, and generally speaking, be a good neighbor.

Accessibility. Keep in mind that many patients are disabled. ADA access is highly appreciated by such people. Access points without proper ADA access may wish to accommodate such patients with delivery service.

Nuisances. In some situations, neighbors have expressed concern about the following things: smell of cannabis products, smell of smoke or vapor, parking issues, littering, patient numbers, street sales outside, smoking in vehicles, loitering, perceived lack of compliance with the law.

Security. Consider security items like locks, safes and lighting. If using video cameras, post clear signage indicating so. Most access points have a front waiting room, and a secure back medicine room. Consider procedures to minimize assets on hand.

Signage and advertising. Health care professionals may not mention medical cannabis in advertising, as per RCW 69.51A.030. It may be that some level of discretion by access points will stave off similar future restrictions placed upon them by the state legislature. Discrete advertising and signage may lessen ill will and complaints from neighbors.

Products. Carrying a wide variety of cannabis and its derivatives is beneficial for many reasons. Specific conditions may be alleviated most beneficially by different products.

Knowledge. Budtenders and everyone handling cannabis are well advised to have knowledge about the strains of cannabis they provide, as well as be able to identify common contaminants like mold, mildew, pests, hair, etc. Seek feedback from patients about one's products.

Public view. One of the few crimes created by I-692 is RCW 69.51A.060(1) which states: “It shall be a class 3 civil infraction to use or display medical cannabis in a manner or place which is open to the view of the general public.” If medical cannabis is visible from outside an access point, that access point is clearly violating this statute.

Storage of patient records

The confidentiality of a patient’s medical cannabis authorization and access point paperwork is a primary concern to many patients. The thought of law enforcement seizing patient records from an access point raises fear and concern in many patients.

An access point needs to have enough paperwork to justify the plants and useable cannabis on hand, but nothing in law requires an access point to keep paperwork on file for every patient to whom they have ever provided medical cannabis. An access point can verify documentation each visit rather than store extraneous paperwork.

If an access point does store patient paperwork, consider off-site records storage -- storing paper records with an attorney, or using encrypted storage on the internet, maybe even “off shore” storage to complicate a potential federal investigation.

Raid preparedness

Operating an access point opens one up to the risk of law enforcement raid. Having a raid plan can help address this constant risk. Here are some potential components of such a plan.

1. **Have attorneys** in place before they are needed. Make sure that all involved

parties are aware of who to call in case of raid. This knowledge decreases stress and helps empower people.

2. **Plan for bail** and a legal defense fund. This will likely be an expensive process. Don’t be afraid to sit in jail for a bit; relax and keep breathing.
3. **Minimize cash** and inventory on hand. Any quantity of cash is a target for “smash and grab” robbery by law enforcement or non-state actors.
4. **Make plans** for child, pet and plant care. Let important people know about the risks one faces.
5. **Shut up.** “I choose to remain silent,” and “I wish to speak to my attorney” are the only phrases needed by all involved. Remain calm.
6. **Record the raid** using video and audio. Many access points have surveillance systems. Many cell phones can record video nowadays.
7. **Contact media** and mobilize support. Assign an off-site contact person to call local media, patients and any supporting organizations that can help. One may contact the Washington State Potline at 888-208-5332 or Americans for Safe Access at 888-929-4367.

The national medical cannabis organization Americans for Safe Access has created comprehensive raid preparedness materials for the medical cannabis community. See the “Raid Preparedness” handout from ASA at:

http://www.safeaccessnow.org/downloads/ASA_Raid_Prep.pdf

Staff

Who may be an employee and successfully claim an affirmative defense?

A designated provider may be employed by a qualifying patient. A qualifying patient may be employed by a collective garden. We are aware of no other situation or relationship where an employee may claim an affirmative defense under RCW 69.51A.

Trust

It is wise to surround oneself with people who are trustworthy. Interviewing potential staff can help evaluate their values and commitment to compliance with laws, rules and standards. Checking references may give employers a better understanding of the staff member's work ethic, and criminal background checks can illuminate the potential staff member's criminal history. (Of course, past cannabis-related offenses only indicate a long-time relationship with the plant, and could be treated as industry experience or employment history.)

Legal compliance

Train staff to understand and comply with RCW 69.51A and specifically, the collective garden language, RCW 69.51A.085. Ensure that staff are familiar with policies and procedures that the access point has implemented to protect its affirmative defense in case of prosecution. Be certain that staff understand the legal theory or model under which the access point is operating. See the *Access Points* section.

Not only is it important for employees to follow the law, but patients also seek this information and will feel better knowing that employees understand the law.

Ongoing training

This is a burgeoning industry, struggling for acceptance and legitimacy, within a confusion of state, city and federal laws, ordinances and regulations. However, it is not a new industry. It is important that all employees continue to be educated and trained on all aspects of the industry.

Be honest

Do not be afraid if one doesn't know the answer to a patient question; be honest. Fabricating answers will ultimately affect patient confidence in access point staff. Some patients have benefited from medical cannabis for many years or decades, and likely have more in-depth knowledge about cannabis than budtenders. Provide ongoing training and information about access point products, policies, procedures and the law, and seek answers to those questions one can't answer with confidence.

Emergency training

Staff need to be familiar with emergency procedures in case of fire, robbery, raid or health emergency. First Aid/CPR training is beneficial for all staff.

Staff or patients may need first aid while

at an access point, as such it is suggested that a “Work Place First-Aid Program” be established for the location. Occupational Safety and Health Administration (OSHA) provides a “best practices guide” for this very purpose:

<http://www.osha.gov/Publications/OSHA3317first-aid.pdf>

Employee handbook

According to the federal Small Business Administration, an employee handbook sets forth expectations for employees, and describes what they can expect from your company. An employee handbook describes an employer’s legal obligations and an employee’s rights.

Employee handbooks may include:

- Non-Disclosure Agreements (NDAs) and Conflict of Interest Statements
- Anti-Discrimination Policies – Employers must abide by equal employment opportunity laws prohibiting discrimination and harassment, including the Americans with Disabilities Act.
- Compensation – employers must consider wage and hour laws, employment taxes and workers’ compensation
- Work schedules – company’s policies around schedules, punctuality, absences.
- Standards of conduct
- Safety and security procedures
- Computers and technology

- Media Relations
- Employee benefits
- Leave policies
- Sexual harassment policy
- Raid plan

For more, see: <http://www.sba.gov/content/employee-handbooks>

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Testing Facilities

In Washington State, the following tests are available for medical cannabis.

Cannabinoid testing

Cannabinoid testing can be used to determine the percentage of THC, CBD, CBN and other cannabinoids in a particular sample of medical cannabis. Several companies now offer cannabinoid testing using some of the following method:

- Thin layer chromatography
- High performance thin layer chromatography
- Gas chromatography mass spectrometry
- Liquid chromatography mass spectrometry
- High pressure liquid chromatography
- Laser refraction

Pesticide testing

Since 1991, the USDA has been charged with collecting data on pesticide residues in food. The Pesticide Data Program is a database of pesticides and their associated “chromatographs.”

By comparing a chromatograph of a cannabis sample against the database of known pesticides, it is possible to determine if a known pesticide is likely present in a sample.

Fungal testing

Two types of testing are currently available for mold, mildew and other fungi:

- (1) Visual inspection; and
- (1) Swabbing, culturing and counting the growth of colonies in a petri dish.

Other tests exist, but are not readily available. If fungi is not distinguishable in a visual inspection, it is unlikely to show up in significant quantity in a culture test.

Terpene testing

Terpenes are organic compounds produced by plants, which are often aromatic, and are major components of plant resins. Many people believe the combination of terpenes and cannabinoids have synergistic health effects. Currently, terpene testing is not available for cannabis in Washington State.

Results may vary

Be aware that cannabis testing is a developing industry, and while it promises to bring a wealth of scientific data to our community, in the short term, producing replicatable results has been a challenge.

Tax Issues

IRC chapter 280E

Federal tax law is codified under Title 26 of the United States Code -- the so-called Internal Revenue Code, or IRC. Deep in the section on calculating taxable income lies a pesky little sentence which denies ordinary business expense deductions related to “trafficking in controlled substances.”

The sentence reads thus:

“No deduction or credit shall be allowed for any amount paid or incurred during the taxable year in carrying on any trade or business if such trade or business (or the activities which comprise such trade or business) consists of trafficking in controlled substances (within the meaning of schedule I and II of the Controlled Substances Act) which is prohibited by Federal law or the law of any State in which such trade or business is conducted.”

Source: 26 USC 280E.

Brief history of 280E

In 1981, the United States Tax Court, tasked with adjudicating disputes over federal income tax, ruled in *Edmondson v. Commissioner* on the tax obligation of a Minnesota drug dealer for the year 1974. The court allowed standard business deductions for vehicle mileage, a scale, long distance phone charges, and the cost of his amphetamines, cocaine and cannabis (\$100 per pound, for the record).

In 1982, the same year President Reagan declared a “war on drugs,” the US Congress

enacted Section 280E of the Internal Revenue Code to deny such tax deductions to drug dealers. They justified this on “public policy grounds,” noting that federal tax code already denies deductions for illegal bribes and kickbacks. The law took effect in 1984.

In the legislative record it is specifically noted that 280E applies to deductions and not cost of good sold (COGS):

“To preclude possible challenges on constitutional grounds, the adjustment to gross receipts with respect to effective costs of goods sold is not affected by this provision of the bill.”

CHAMP v. IRS

In 1998 California voters passed the nation’s first medical cannabis law. Tax year 2002 was the first year a dispensary 1) filed its taxes, 2) indicated the true nature of its business, 3) was audited and denied ordinary business deductions, and 4) appealed the ruling to tax court. The final ruling in *Californians Helping Alleviate Medical Problems v. Commissioner of Internal Revenue* -- better known as *CHAMP v. IRS* -- was the first published guidance on the effect of 280E on medical cannabis access points in states that have legalized such activity. Read it here:

<http://www.ustaxcourt.gov/inophistoric/champ.tc.wpd.pdf>

CHAMP was incorporated in 1996 and served severely ill patients -- primarily AIDS patients -- with both caregiving services and medical cannabis. The caregiving services included weekly support groups, daily

lunches for low-income members, free hygiene supplies, counseling, social events, monthly field trips, yoga, computer access, and political advocacy support. Members also received a fixed amount of medical cannabis every month as part of their monthly dues.

CHAMP closed shop in 2002 and filed a “Final Return” on Form 1120, the standard corporate return. In it they claimed just over \$1 million in gross revenue. They deducted \$835k for “Cost of Good Sold” (COGS) -- mostly for cannabis procurement -- and the remaining \$213k in gross profit was deducted as standard business expenses -- salaries, taxes, rent, insurance, utilities, legal, etc.

The IRS originally denied CHAMP all of its deductions and cost of goods sold, but “conceded” that COGS is deductible. Furthermore, they conceded that the \$213k in deductions were substantiated, distilling the court issue down to this: which deductions are “expenditures in connection with the illegal sale of drugs” within the meaning of 280E?

First, the court ruled that CHAMP was engaged in two “trades or businesses” and that a taxpayer may deduct business expenses for a non-trafficking trade or business even if they are simultaneously engaged in a trafficking trade or business. The IRS had originally taken the position that any involvement in cannabis distribution was grounds to deny all deductions to a taxpayer.

Second, the court ruled that CHAMP’s distribution of medical cannabis was “trafficking” within the meaning of 280E by buying and selling cannabis -- even though the cost of cannabis was wrapped into a monthly membership fee that came with myriad other caregiving services.

Third, the court ruled that CHAMP’s two distinct businesses are “separate activities” for tax purposes, noting again that the caregiving services were regular, extensive and substantially different from its provision of medical cannabis. The IRS had argued that all of CHAMP’s caregiving activities were “incidental” to its primary business of medical cannabis trafficking.

Lastly, the court calculated CHAMP’s non-deductible “trafficking related” expenses.

CHAMP math

The court allowed all deductions unrelated to medical cannabis -- the church office and meeting space the group rented, truck and auto expenses, laundry and cleaning service, etc.

The court broke down the non-deductible expenses into two categories: employee expenses and facility expenses. It allocated 7 of 25 employee expenses to trafficking-related business, because only 7 of 25 employees had anything to do with the medical cannabis dispensing. It allocated 10% of the facility expenses to trafficking, noting that “90 percent of the square footage of petitioner’s main facility was not used in petitioner’s provision of medical marijuana.”

On \$100k in normally-deductible employee expenses, CHAMP was ordered to pay taxes on \$28k, 7/25 of the claim. These included “salaries, wages, payroll taxes, employee benefits, employee development training, meals and entertainment, and parking and tolls.”

On the \$92k in facilities and other expenses, CHAMP was ordered to pay tax on \$9.2k, 1/10 of the claim. Thus the defunct non-profit was required to pay taxes on between

\$32,700 and \$37,000. At 15% corporate tax rate (for the first \$50k of profit), the amount of tax CHAMP owed the IRS at the end of the day, according to the Sacramento Bee, was \$4,905.

Post-CHAMP Zamarra math

Luigi Zamarra, the Chief Financial Officer for California's largest medical cannabis access point, Harborside, authored an article that proposed how access points should calculate their non-deductible "trafficking related" business expenses in the aftermath of the CHAMP ruling. The article, in modified form, can be found at:

http://www.luigicpa.com/?page_id=95

Zamarra quoted CHAMP where the court wrote: "We define and apply the gerund 'trafficking' by reference to the verb 'traffic', which as relevant herein denotes 'to engage in commercial activity: buy and sell regularly'."

Thus, Zamarra advised: "In the context of a medical cannabis dispensary, it should only include the consummation of the actual financial transaction. Informal studies have shown that, of the total amount of time the typical patients spends at the dispensary counter, less than 25% of that time is spent consummating the financial transaction, i.e., swiping their credit card or handling money. This percentage is what I call the 'Transactional Factor.'"

The CHAMP ruling simply divided the number of employees involved in "trafficking" by the total number of employees, and used that number to calculate what percentage of employee expenses were non-deductible. It did not take into consideration that the 7 of 25 employees involved in "trafficking" spent only some of the time involved in that trade

or business, and some of the time involved in fully deductible "non-trafficking" activities. This was at least in part due to the fact that the court record showed no calculation or substantiation of such a break down.

Zamarra advised making such a record by literally timing medical cannabis transactions, counting the seconds the employee spends providing ostensibly deductible services like social interaction, education and information versus the time spent swiping a credit card or exchanging currency. If 25% of the counter employee time is spent actually transacting cannabis and cash, 25% of expenses related to those counter employees are non-deductible.

So, for example, suppose an access point has 4 employees, 2 of whom dispense cannabis. The "keeper of the math" calculates, using a stop watch, the amount of time spent "trafficking" over 10 or 20 transactions. They decide it is 25%. The two employees earn a total of \$80,000 a year between them, including benefits. The access point decides it's non-deductible employee expenses are \$20,000 (25% of \$80k). This is part of the non-deductible income on which one must pay taxes to the federal government.

For facility expenses, Zamarra advised measuring the space around the retail counter, and dividing that by the total square footage of the facility. After arriving at the percentage of "retail space," Zamarra advised multiplying that by the so-called "transactional factor" -- the amount of time counter employees spent "trafficking" versus other services.

The CHAMP ruling allowed the calculation of the amount of square footage used for "trafficking," but it did not factor in the amount of time those spaces were actually used for "trafficking." This was, again, in

part due to the lack of substantiating records presented to the tax court. Zamarra advised calculating and documenting this percentage and applying it to facility expenses.

So, for example, suppose an access point has a 1,000 square foot facility, and 100 square feet of that is retail counter area. This access point has calculated and documented that 25% of its counter employee time is non-deductible “trafficking” expenses. If they pay \$36,000 a year for rent, \$3,600 of that is related to the retail area, and 25% of that -- or \$900 -- would be non-deductible “trafficking” expenses. This much-smaller amount would be part of the company’s taxable income.

Harborside audit

Harborside CFO Zamarra wrote: “The IRS might attempt to question or challenge this approach. Stick to your guns! The practitioner is advised to hold fast to the position.”

Harborside had the opportunity to put its theory to the test when the IRS audited them in 2010. The access point had claimed an estimated \$22 million per year in gross revenues, had 80+ employees and multiple locations. The group’s Executive Director revealed in 2010 that the IRS had denied its deduction calculations and hit them with a \$2 million tax assessment.

And just as CHAMP v. IRS provided greater clarity to medical cannabis providers trying to comply with federal tax code, Harborside v. IRS will provide further clarity to our community. Until then, be aware that using anything beyond the simple calculations in CHAMP may risk a similar tax assessment.

Basic suggestions

The more money in play, the more money in play. In an uncertain world, strive for sustainability, not enormity. The larger the gross receipts, and the larger the deductions, the larger the potential tax penalty. At the lowest 15% corporate tax rate, every \$10,000 in disputed deductions could cost \$1,500.

Discretion is the better part of valor.

It may seem unbelievable that people are filing taxes claiming non-deductible “drug trafficking” expenses, that they are, to some degree, informing the federal government on their federal law violations. Some things that might cause one to be at higher risk of audit include bringing in large amounts of revenue, media attention, and proposing untested tax calculations to amend Tax Court-ruled math.

Cost of Goods Sold. Money spent on cannabis products is deductible. Money paid to growers is deductible. Retail employees who transact cannabis are non-deductible.

Less “trafficking,” more patient services.

The less space dedicated to “trafficking” activity the lower the non-deductible facility expenses. Limit the retail area and maximize other service areas to reduce the non-deductible tax burden. CHAMP provided peer support groups, counseling, yoga, free meals, social events, political advocacy, etc. Some other services access points may offer include massage, acupuncture, cannabis testing, garden consulting, etc.

Minimize “trafficking” employees.

Limit the number of people who act as “budtenders.” Arguments over non-deductible employee expenses will center around these employees.

Document calculations and non-trafficking activity. An access point may be pressed to substantiate its calculations. If employee transactions were timed to determine what percentage of the time was dedicated to “trafficking,” have that clearly documented. Keep records of other business activities -- the yoga flyer, the events calendar, the email announcing the field trip to the capitol, the massage practitioner schedule, etc.

Document Cost of Goods Sold. Issue carbon-copy receipts, or some other form of documentation, when paying vendors. The IRS did not challenge the COGS calculations in the CHAMP case, but they could in your case.

Washington State sales tax

In December 2010 the Washington State Department of Revenue issued an opinion that the sales of medical cannabis are not specifically exempted under the state sales tax law, which exempts medicine prescribed by a doctor, but not medical cannabis, which is “recommended.” DOR sent notice to suspected access points demanding they pay sales tax. Many access points have complied.

In 2011, Governor Gregoire made clear that she will not involve public employees in any possible violations of federal law, including placing them on-site at grow operations and collecting cannabis-related taxes.

The Cannabis Defense Coalition believes that medical cannabis should be taxed as would any other therapeutic drug. Furthermore, state and local law enforcement routinely ignore the law and raid authorized patients and providers. Thus, funding those who seek to imprison us is unwise, and registering with the state as violating federal law is akin

to painting a target on one’s head, and we recommend against these things.

In the State of Washington, medical cannabis food products are certainly not subject to sales tax. See RCW 82.08.0293.

Business and occupation taxes

Businesses in Washington State are required to file a Business and Occupation Tax report with the Washington State Department of Revenue. The state B&O tax is a gross receipts tax. It is measured on the value of products, gross proceeds of sale, or gross income of the business.

<http://dor.wa.gov/content/findtaxesandrates/bandotax/>

Tax accountant

Many medical cannabis businesses need a tax accountant who can understand and help them comply with IRC 280E. While some accountants are starting to advertise as “cannabis-friendly,” any experienced accountant can help a business classify expenses into categories that comply with the CHAMP ruling. They simply must be willing to have a medical cannabis business as a client.

STAY CONNECTED AND CURRENT.

Sign up for free weekly email alerts from the Cannabis Defense Coalition to learn about medical cannabis court cases, upcoming events, and activist projects in Washington State.

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RCW 69.51A

69.51A.005

Purpose and intent.

- (1) The legislature finds that:
 - (a) There is medical evidence that some patients with terminal or debilitating medical conditions may, under their health care professional's care, benefit from the medical use of cannabis. Some of the conditions for which cannabis appears to be beneficial include, but are not limited to:
 - (i) Nausea, vomiting, and cachexia associated with cancer, HIV-positive status, AIDS, hepatitis C, anorexia, and their treatments;
 - (ii) Severe muscle spasms associated with multiple sclerosis, epilepsy, and other seizure and spasticity disorders;
 - (iii) Acute or chronic glaucoma;
 - (iv) Crohn's disease; and
 - (v) Some forms of intractable pain.
 - (b) Humanitarian compassion necessitates that the decision to use cannabis by patients with terminal or debilitating medical conditions is a personal, individual decision, based upon their health care professional's professional medical judgment and discretion.
- (2) Therefore, the legislature intends that:
 - (a) Qualifying patients with terminal or debilitating medical conditions who, in the judgment of their health care professionals, may benefit from the medical use of cannabis, shall not be arrested, prosecuted, or subject to other criminal sanctions or civil consequences under state law based solely on their medical use of cannabis, notwithstanding any other provision of law;
 - (b) Persons who act as designated providers to such patients shall also not be arrested, prosecuted, or subject to other criminal sanctions or civil consequences under state law, notwithstanding any other provision of law, based solely on their assisting with the medical use of cannabis; and
 - (c) Health care professionals shall also not be arrested,

prosecuted, or subject to other criminal sanctions or civil consequences under state law for the proper authorization of medical use of cannabis by qualifying patients for whom, in the health care professional's professional judgment, the medical use of cannabis may prove beneficial.

- (3) Nothing in this chapter establishes the medical necessity or medical appropriateness of cannabis for treating terminal or debilitating medical conditions as defined in RCW 69.51A.010.
- (4) Nothing in this chapter diminishes the authority of correctional agencies and departments, including local governments or jails, to establish a procedure for determining when the use of cannabis would impact community safety or the effective supervision of those on active supervision for a criminal conviction, nor does it create the right to any accommodation of any medical use of cannabis in any correctional facility or jail.

69.51A.010

Definitions.

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

- (1) "Designated provider" means a person who:
 - (a) Is eighteen years of age or older;
 - (b) Has been designated in writing by a patient to serve as a designated provider under this chapter;
 - (c) Is prohibited from consuming marijuana obtained for the personal, medical use of the patient for whom the individual is acting as designated provider; and
 - (d) Is the designated provider to only one patient at any one time.
- (2) "Health care professional," for purposes of this chapter only, means a physician licensed under chapter 18.71 RCW, a physician assistant licensed under chapter 18.71A RCW, an osteopathic physician licensed under chapter 18.57 RCW, an osteopathic physicians' assistant licensed under chapter 18.57A RCW, a naturopath licensed under chapter 18.36A RCW, or an advanced registered nurse practitioner licensed under chapter 18.79

RCW.

- (3) “Medical use of marijuana” means the production, possession, or administration of marijuana, as defined in RCW 69.50.101(q), for the exclusive benefit of a qualifying patient in the treatment of his or her terminal or debilitating illness.
- (4) “Qualifying patient” means a person who:
 - (a) Is a patient of a health care professional;
 - (b) Has been diagnosed by that health care professional as having a terminal or debilitating medical condition;
 - (c) Is a resident of the state of Washington at the time of such diagnosis;
 - (d) Has been advised by that health care professional about the risks and benefits of the medical use of marijuana; and
 - (e) Has been advised by that health care professional that they may benefit from the medical use of marijuana.
- (5) “Tamper-resistant paper” means paper that meets one or more of the following industry-recognized features:
 - (a) One or more features designed to prevent copying of the paper;
 - (b) One or more features designed to prevent the erasure or modification of information on the paper; or
 - (c) One or more features designed to prevent the use of counterfeit valid documentation.
- (6) “Terminal or debilitating medical condition” means:
 - (a) Cancer, human immunodeficiency virus (HIV), multiple sclerosis, epilepsy or other seizure disorder, or spasticity disorders; or
 - (b) Intractable pain, limited for the purpose of this chapter to mean pain unrelieved by standard medical treatments and medications; or
 - (c) Glaucoma, either acute or chronic, limited for the purpose of this chapter to mean increased intraocular pressure unrelieved by standard treatments and medications; or
 - (d) Crohn’s disease with debilitating symptoms unrelieved by standard treatments or medications; or
 - (e) Hepatitis C with debilitating nausea or intractable pain unrelieved by standard treatments or medications; or
 - (f) Diseases, including anorexia, which result in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, or spasticity, when these symptoms are unrelieved by standard treatments or medications; or
 - (g) Any other medical condition duly approved by the Washington state medical quality assurance commission in consultation with the board of osteopathic medicine and surgery as directed in this chapter.
- (7) “Valid documentation” means:
 - (a) A statement signed and dated by a qualifying patient’s health care professional written on tamper-resistant paper, which states that, in the health care professional’s professional opinion, the patient may benefit from the medical use of marijuana; and
 - (b) Proof of identity such as a Washington state driver’s license or identicard, as defined in RCW 46.20.035.

69.51A.020

Construction of chapter.

Nothing in this chapter shall be construed to supersede Washington state law prohibiting the acquisition, possession, manufacture, sale, or use of cannabis for nonmedical purposes. Criminal penalties created under chapter 181, Laws of 2011 do not preclude the prosecution or punishment for other crimes, including other crimes involving the manufacture or delivery of cannabis for nonmedical purposes.

69.51A.025

Construction of chapter —

Compliance with RCW 69.51A.040.

Nothing in this chapter or in the rules adopted to implement it precludes a qualifying patient or designated provider from engaging in the private, unlicensed, noncommercial production, possession, transportation, delivery, or administration of cannabis for medical use as authorized under RCW 69.51A.040.

69.51A.030

Acts not constituting crimes or unprofessional conduct — Health care professionals not subject to penalties or liabilities.

(1) The following acts do not constitute crimes under state law or unprofessional conduct under chapter 18.130 RCW, and a health care professional may not be arrested, searched, prosecuted, disciplined, or subject to other criminal sanctions or civil consequences or liability under state law, or have real or personal property searched, seized, or forfeited pursuant to state law, notwithstanding any other provision of law as long as the health care professional complies with subsection (2) of this section:

- (a) Advising a patient about the risks and benefits of medical use of cannabis or that the patient may benefit from the medical use of cannabis; or
- (b) Providing a patient meeting the criteria established under *RCW 69.51A.010(26) with valid documentation, based upon the health care professional's assessment of the patient's medical history and current medical condition, where such use is within a professional standard of care or in the individual health care professional's medical judgment.

(2)

- (a) A health care professional may only provide a patient with valid documentation authorizing the medical use of cannabis or register the patient with the registry established in **section 901 of this act if he or she has a newly initiated or existing documented relationship with the patient, as a primary care provider or a specialist, relating to the diagnosis and ongoing treatment or monitoring of the patient's terminal or debilitating medical condition, and only after:
 - (i) Completing a physical examination of the patient as appropriate, based on the patient's condition and age;
 - (ii) Documenting the terminal or debilitating medical condition of the patient in the patient's medical record and that the patient may benefit from treatment of this condition or its symptoms with medical use of cannabis;
 - (iii) Informing the patient of other options for treating the terminal or debilitating medical condition; and

- (iv) Documenting other measures attempted to treat the terminal or debilitating medical condition that do not involve the medical use of cannabis.

(b) A health care professional shall not:

- (i) Accept, solicit, or offer any form of pecuniary remuneration from or to a licensed dispenser, licensed producer, or licensed processor of cannabis products;
- (ii) Offer a discount or any other thing of value to a qualifying patient who is a customer of, or agrees to be a customer of, a particular licensed dispenser, licensed producer, or licensed processor of cannabis products;
- (iii) Examine or offer to examine a patient for purposes of diagnosing a terminal or debilitating medical condition at a location where cannabis is produced, processed, or dispensed;
- (iv) Have a business or practice which consists solely of authorizing the medical use of cannabis;
- (v) Include any statement or reference, visual or otherwise, on the medical use of cannabis in any advertisement for his or her business or practice; or
- (vi) Hold an economic interest in an enterprise that produces, processes, or dispenses cannabis if the health care professional authorizes the medical use of cannabis.

(3) A violation of any provision of subsection (2) of this section constitutes unprofessional conduct under chapter 18.130 RCW.

69.51A.040

Compliance with chapter — Qualifying patients and designated providers not subject to penalties — Law enforcement not subject to liability.

The medical use of cannabis in accordance with the terms and conditions of this chapter does not constitute a crime and a qualifying patient or designated provider in compliance with the terms and conditions of this chapter may not be arrested, prosecuted, or subject to other criminal sanctions or civil consequences, for possession, manufacture, or delivery of, or for possession with intent to manufacture or deliver,

cannabis under state law, or have real or personal property seized or forfeited for possession, manufacture, or delivery of, or for possession with intent to manufacture or deliver, cannabis under state law, and investigating peace officers and law enforcement agencies may not be held civilly liable for failure to seize cannabis in this circumstance, if:

- (1)
 - (a) The qualifying patient or designated provider possesses no more than fifteen cannabis plants and:
 - (i) No more than twenty-four ounces of useable cannabis;
 - (ii) No more cannabis product than what could reasonably be produced with no more than twenty-four ounces of useable cannabis; or
 - (iii) A combination of useable cannabis and cannabis product that does not exceed a combined total representing possession and processing of no more than twenty-four ounces of useable cannabis.
 - (b) If a person is both a qualifying patient and a designated provider for another qualifying patient, the person may possess no more than twice the amounts described in (a) of this subsection, whether the plants, useable cannabis, and cannabis product are possessed individually or in combination between the qualifying patient and his or her designated provider;
- (2) The qualifying patient or designated provider presents his or her proof of registration with the department of health, to any peace officer who questions the patient or provider regarding his or her medical use of cannabis;
- (3) The qualifying patient or designated provider keeps a copy of his or her proof of registration with the registry established in *section 901 of this act and the qualifying patient or designated provider's contact information posted prominently next to any cannabis plants, cannabis products, or useable cannabis located at his or her residence;
- (4) The investigating peace officer does not possess evidence that:
 - (a) The designated provider has converted cannabis produced or obtained for the qualifying patient for his or her own personal use or benefit; or
 - (b) The qualifying patient has converted cannabis produced or obtained for his or her own

medical use to the qualifying patient's personal, nonmedical use or benefit;

- (5) The investigating peace officer does not possess evidence that the designated provider has served as a designated provider to more than one qualifying patient within a fifteen-day period; and
- (6) The investigating peace officer has not observed evidence of any of the circumstances identified in *section 901(4) of this act.

69.51A.043

Failure to register — Affirmative defense.

- (1) A qualifying patient or designated provider who is not registered with the registry established in *section 901 of this act may raise the affirmative defense set forth in subsection (2) of this section, if:
 - (a) The qualifying patient or designated provider presents his or her valid documentation to any peace officer who questions the patient or provider regarding his or her medical use of cannabis;
 - (b) The qualifying patient or designated provider possesses no more cannabis than the limits set forth in RCW 69.51A.040(1);
 - (c) The qualifying patient or designated provider is in compliance with all other terms and conditions of this chapter;
 - (d) The investigating peace officer does not have probable cause to believe that the qualifying patient or designated provider has committed a felony, or is committing a misdemeanor in the officer's presence, that does not relate to the medical use of cannabis;
 - (e) No outstanding warrant for arrest exists for the qualifying patient or designated provider; and
 - (f) The investigating peace officer has not observed evidence of any of the circumstances identified in *section 901(4) of this act.
- (2) A qualifying patient or designated provider who is not registered with the registry established in *section 901 of this act, but who presents his or her valid documentation to any peace officer who questions the patient or provider regarding his or her medical use of cannabis, may assert an affirmative defense to charges of violations of state law relating to cannabis through proof at trial, by a preponderance of the evidence, that he

or she otherwise meets the requirements of RCW 69.51A.040. A qualifying patient or designated provider meeting the conditions of this subsection but possessing more cannabis than the limits set forth in RCW 69.51A.040(1) may, in the investigating peace officer's discretion, be taken into custody and booked into jail in connection with the investigation of the incident.

69.51A.045

Possession of cannabis exceeding lawful amount — Affirmative defense.

A qualifying patient or designated provider in possession of cannabis plants, useable cannabis, or cannabis product exceeding the limits set forth in RCW 69.51A.040(1) but otherwise in compliance with all other terms and conditions of this chapter may establish an affirmative defense to charges of violations of state law relating to cannabis through proof at trial, by a preponderance of the evidence, that the qualifying patient's necessary medical use exceeds the amounts set forth in RCW 69.51A.040(1). An investigating peace officer may seize cannabis plants, useable cannabis, or cannabis product exceeding the amounts set forth in RCW 69.51A.040(1): PROVIDED, That in the case of cannabis plants, the qualifying patient or designated provider shall be allowed to select the plants that will remain at the location. The officer and his or her law enforcement agency may not be held civilly liable for failure to seize cannabis in this circumstance.

69.51A.047

Failure to register or present valid documentation — Affirmative defense.

A qualifying patient or designated provider who is not registered with the registry established in *section 901 of this act or does not present his or her valid documentation to a peace officer who questions the patient or provider regarding his or her medical use of cannabis but is in compliance with all other terms and conditions of this chapter may establish an affirmative defense to charges of violations of state law relating to cannabis through proof at trial, by a preponderance of the evidence, that he or she was a validly authorized qualifying patient or designated provider at the time of the officer's questioning. A qualifying patient or designated provider who establishes an affirmative defense under the terms of this section may also establish an affirmative defense under RCW 69.51A.045.

69.51A.050

Medical marijuana, lawful possession — State not liable.

- (1) The lawful possession or manufacture of medical marijuana as authorized by this chapter shall not result in the forfeiture or seizure of any property.
- (2) No person shall be prosecuted for constructive possession, conspiracy, or any other criminal offense solely for being in the presence or vicinity of medical marijuana or its use as authorized by this chapter.
- (3) The state shall not be held liable for any deleterious outcomes from the medical use of marijuana by any qualifying patient.

69.51A.055

Limitations of chapter — Persons under supervision.

- (1)
 - (a) The arrest and prosecution protections established in RCW 69.51A.040 may not be asserted in a supervision revocation or violation hearing by a person who is supervised by a corrections agency or department, including local governments or jails, that has determined that the terms of this section are inconsistent with and contrary to his or her supervision.
 - (b) The affirmative defenses established in RCW 69.51A.043, 69.51A.045, 69.51A.047, and *section 407 of this act may not be asserted in a supervision revocation or violation hearing by a person who is supervised by a corrections agency or department, including local governments or jails, that has determined that the terms of this section are inconsistent with and contrary to his or her supervision.
- (2) The provisions of RCW 69.51A.040, 69.51A.085, and 69.51A.025 do not apply to a person who is supervised for a criminal conviction by a corrections agency or department, including local governments or jails, that has determined that the terms of this chapter are inconsistent with and contrary to his or her supervision.
- (3) A person may not be licensed as a licensed producer, licensed processor of cannabis products, or a licensed dispenser under *section 601, 602, or 701 of this act if he or she is supervised for a criminal conviction by a corrections agency or department, including local governments or jails,

that has determined that licensure is inconsistent with and contrary to his or her supervision.

69.51A.060

Crimes — Limitations of chapter.

- (1) It shall be a class 3 civil infraction to use or display medical cannabis in a manner or place which is open to the view of the general public.
- (2) Nothing in this chapter establishes a right of care as a covered benefit or requires any state purchased health care as defined in RCW 41.05.011 or other health carrier or health plan as defined in Title 48 RCW to be liable for any claim for reimbursement for the medical use of cannabis. Such entities may enact coverage or noncoverage criteria or related policies for payment or nonpayment of medical cannabis in their sole discretion.
- (3) Nothing in this chapter requires any health care professional to authorize the medical use of cannabis for a patient.
- (4) Nothing in this chapter requires any accommodation of any on-site medical use of cannabis in any place of employment, in any school bus or on any school grounds, in any youth center, in any correctional facility, or smoking cannabis in any public place or hotel or motel.
- (5) Nothing in this chapter authorizes the use of medical cannabis by any person who is subject to the Washington code of military justice in chapter 38.38 RCW.
- (6) Employers may establish drug-free work policies. Nothing in this chapter requires an accommodation for the medical use of cannabis if an employer has a drug-free work place.
- (7) It is a class C felony to fraudulently produce any record purporting to be, or tamper with the content of any record for the purpose of having it accepted as, valid documentation under *RCW 69.51A.010(32) (a), or to backdate such documentation to a time earlier than its actual date of execution.
- (8) No person shall be entitled to claim the protection from arrest and prosecution under RCW 69.51A.040 or the affirmative defense under RCW 69.51A.043 for engaging in the medical use of cannabis in a way that endangers the health or well-being of any person through the use of a motorized vehicle on a street, road, or highway, including violations of RCW 46.61.502 or 46.61.504, or equivalent local ordinances.

69.51A.070

Addition of medical conditions.

The Washington state medical quality assurance commission in consultation with the board of osteopathic medicine and surgery, or other appropriate agency as designated by the governor, shall accept for consideration petitions submitted to add terminal or debilitating conditions to those included in this chapter. In considering such petitions, the Washington state medical quality assurance commission in consultation with the board of osteopathic medicine and surgery shall include public notice of, and an opportunity to comment in a public hearing upon, such petitions. The Washington state medical quality assurance commission in consultation with the board of osteopathic medicine and surgery shall, after hearing, approve or deny such petitions within one hundred eighty days of submission. The approval or denial of such a petition shall be considered a final agency action, subject to judicial review.

69.51A.085

Collective gardens.

- (1) Qualifying patients may create and participate in collective gardens for the purpose of producing, processing, transporting, and delivering cannabis for medical use subject to the following conditions:
 - (a) No more than ten qualifying patients may participate in a single collective garden at any time;
 - (b) A collective garden may contain no more than fifteen plants per patient up to a total of forty-five plants;
 - (c) A collective garden may contain no more than twenty-four ounces of useable cannabis per patient up to a total of seventy-two ounces of useable cannabis;
 - (d) A copy of each qualifying patient's valid documentation or proof of registration with the registry established in *section 901 of this act, including a copy of the patient's proof of identity, must be available at all times on the premises of the collective garden; and
 - (e) No useable cannabis from the collective garden is delivered to anyone other than one of the qualifying patients participating in the collective garden.
- (2) For purposes of this section, the creation of a "collective garden" means qualifying patients sharing responsibility for acquiring and supplying the resources required to produce and process

cannabis for medical use such as, for example, a location for a collective garden; equipment, supplies, and labor necessary to plant, grow, and harvest cannabis; cannabis plants, seeds, and cuttings; and equipment, supplies, and labor necessary for proper construction, plumbing, wiring, and ventilation of a garden of cannabis plants.

- (3) A person who knowingly violates a provision of subsection (1) of this section is not entitled to the protections of this chapter.

69.51A.090

Applicability of valid documentation definition.

The provisions of RCW 69.51A.010, relating to the definition of “valid documentation,” apply prospectively only, not retroactively, and do not affect valid documentation obtained prior to June 10, 2010.

69.51A.100

Qualifying patient’s designation of provider — Provider’s service as designated provider — Termination.

- (1) A qualifying patient may revoke his or her designation of a specific provider and designate a different provider at any time. A revocation of designation must be in writing, signed and dated. The protections of this chapter cease to apply to a person who has served as a designated provider to a qualifying patient seventy-two hours after receipt of that patient’s revocation of his or her designation.
- (2) A person may stop serving as a designated provider to a given qualifying patient at any time. However, that person may not begin serving as a designated provider to a different qualifying patient until fifteen days have elapsed from the date the last qualifying patient designated him or her to serve as a provider.

69.51A.110

Suitability for organ transplant.

A qualifying patient’s medical use of cannabis as authorized by a health care professional may not be a sole disqualifying factor in determining the patient’s suitability for an organ transplant, unless it is shown that this use poses a significant risk of rejection or organ failure. This section does not preclude a health care professional from requiring that a patient abstain from the medical use of cannabis, for a period of time determined by the health care professional, while

waiting for a transplant organ or before the patient undergoes an organ transplant.

69.51A.120

Parental rights or residential time — Not to be restricted.

A qualifying patient or designated provider may not have his or her parental rights or residential time with a child restricted solely due to his or her medical use of cannabis in compliance with the terms of this chapter absent written findings supported by evidence that such use has resulted in a long-term impairment that interferes with the performance of parenting functions as defined under RCW 26.09.004.

69.51A.130

State and municipalities — Not subject to liability.

- (1) No civil or criminal liability may be imposed by any court on the state or its officers and employees for actions taken in good faith under this chapter and within the scope of their assigned duties.
- (2) No civil or criminal liability may be imposed by any court on cities, towns, and counties or other municipalities and their officers and employees for actions taken in good faith under this chapter and within the scope of their assigned duties.

69.51A.140

Counties, cities, towns — Authority to adopt and enforce requirements.

- (1) Cities and towns may adopt and enforce any of the following pertaining to the production, processing, or dispensing of cannabis or cannabis products within their jurisdiction: Zoning requirements, business licensing requirements, health and safety requirements, and business taxes. Nothing in chapter 181, Laws of 2011 is intended to limit the authority of cities and towns to impose zoning requirements or other conditions upon licensed dispensers, so long as such requirements do not preclude the possibility of siting licensed dispensers within the jurisdiction. If the jurisdiction has no commercial zones, the jurisdiction is not required to adopt zoning to accommodate licensed dispensers.
- (2) Counties may adopt and enforce any of the following pertaining to the production, processing, or dispensing of cannabis or cannabis products within their jurisdiction in locations outside of the corporate limits of any city or town: Zoning

requirements, business licensing requirements, and health and safety requirements. Nothing in chapter 181, Laws of 2011 is intended to limit the authority of counties to impose zoning requirements or other conditions upon licensed dispensers, so long as such requirements do not preclude the possibility of siting licensed dispensers within the jurisdiction. If the jurisdiction has no commercial zones, the jurisdiction is not required to adopt zoning to accommodate licensed dispensers.

69.51A.200

Evaluation.

- (1) By July 1, 2014, the Washington state institute for public policy shall, within available funds, conduct a cost-benefit evaluation of the implementation of chapter 181, Laws of 2011 and the rules adopted to carry out its purposes.
- (2) The evaluation of the implementation of chapter 181, Laws of 2011 and the rules adopted to carry out its purposes shall include, but not necessarily be limited to, consideration of the following factors:
 - (a) Qualifying patients' access to an adequate source of cannabis for medical use;
 - (b) Qualifying patients' access to a safe source of cannabis for medical use;
 - (c) Qualifying patients' access to a consistent source of cannabis for medical use;
 - (d) Qualifying patients' access to a secure source of cannabis for medical use;
 - (e) Qualifying patients' and designated providers' contact with law enforcement and involvement in the criminal justice system;
 - (f) Diversion of cannabis intended for medical use to nonmedical uses;
 - (g) Incidents of home invasion burglaries, robberies, and other violent and property crimes associated with qualifying patients accessing cannabis for medical use;
 - (h) Whether there are health care professionals who make a disproportionately high amount of authorizations in comparison to the health care professional community at large;
 - (i) Whether there are indications of health care professionals in violation of RCW 69.51A.030; and

- (j) Whether the health care professionals making authorizations reside in this state or out of this state.
- (3) For purposes of facilitating this evaluation, the departments of health and agriculture will make available to the Washington state institute for public policy requested data, and any other data either department may consider relevant, from which all personally identifiable information has been redacted.

6.51A.900

Short title — 1999 c 2.

This chapter may be known and cited as the Washington state medical use of cannabis act.

69.51A.901

Severability — 1999 c 2.

If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

69.51A.902

Captions not law — 1999 c 2.

Captions used in this chapter are not any part of the law.

69.51A.903

Severability — 2011 c 181.

If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act that can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

I-692 Original Text

To understand how we arrived at our current place in history, it is important to understand our past. Thus we are re-printing the original text of Initiative 692, as it is often useful to discussions about law, politics and activism. Be aware that this is not the current law.

Sec. 1. TITLE.

This chapter may be known and cited as the Washington state medical use of marijuana act.

Sec. 2. PURPOSE AND INTENT.

The People of Washington state find that some patients with terminal or debilitating illnesses, under their physician's care, may benefit from the medical use of marijuana. Some of the illnesses for which marijuana appears to be beneficial include chemotherapy-related nausea and vomiting in cancer patients; AIDS wasting syndrome; severe muscle spasms associated with multiple sclerosis and other spasticity disorders; epilepsy; acute or chronic glaucoma; and some forms of intractable pain.

The People find that humanitarian compassion necessitates that the decision to authorize the medical use of marijuana by patients with terminal or debilitating illnesses is a personal, individual decision, based upon their physician's professional medical judgment and discretion.

Therefore, The people of the state of Washington intend that:

Qualifying patients with terminal or debilitating illnesses who, in the judgment of their physicians, would benefit from the medical use of marijuana, shall not be found guilty of a crime under state law for their possession and limited use of marijuana;

Persons who act as primary caregivers to such patients shall also not be found guilty of a crime under state law for assisting with the medical use of marijuana; and

Physicians also be excepted from liability and prosecution for the authorization of marijuana use to qualifying patients for whom, in the physician's professional judgment, medical marijuana may prove beneficial.

Sec. 3. NON-MEDICAL PURPOSES PROHIBITED.

Nothing in this chapter shall be construed to supersede Washington state law prohibiting the acquisition, possession, manufacture, sale, or use of marijuana for non-medical purposes.

Sec. 4. PROTECTING PHYSICIANS AUTHORIZING THE USE OF MEDICAL MARIJUANA.

A physician licensed under chapter 18.71 RCW or chapter 18.57 RCW shall be excepted from the state's criminal laws and shall not be penalized in any manner, or denied any right or privilege, for:

1. Advising a qualifying patient about the risks and benefits of medical use of marijuana or that the qualifying patient may benefit from the medical use of marijuana where such use is within a professional standard of care or in the individual physician's medical judgment; or
2. Providing a qualifying patient with valid documentation, based upon the physician's assessment of the qualifying patient's medical history and current medical condition, that the potential benefits of the medical use of marijuana would likely outweigh the health risks for the particular qualifying patient.

Sec. 5. PROTECTING QUALIFYING PATIENTS AND PRIMARY CAREGIVERS.

1. If charged with a violation of state law relating to marijuana, any qualifying patient who is engaged in the medical use of marijuana, or any designated primary caregiver who assists a qualifying patient in the medical use of marijuana, will be deemed to have established an affirmative defense to such charges by proof of his or her compliance with the requirements provided in this chapter. Any person meeting the requirements appropriate to his or her status under this chapter shall be considered to have engaged in activities permitted by this chapter and shall not be penalized in any manner, or denied any

right or privilege, for such actions.

2. The qualifying patient, if eighteen years of age or older, shall:

- a. Meet all criteria for status as a qualifying patient;
- b. Possess no more marijuana than is necessary for the patient's personal, medical use, not exceeding the amount necessary for a sixty day supply; and
- c. Present his or her valid documentation to any law enforcement official who questions the patient regarding his or her medical use of marijuana.

3. The qualifying patient, if under eighteen years of age, shall comply with subsection (2) (a) and (c) of this section. However, any possession under subsection (2) (b) of this act, as well as any production, acquisition, and decision as to dosage and frequency of use, shall be the responsibility of the parent or legal guardian of the qualifying patient.

4. The designated primary caregiver shall:

- a. Meet all criteria for status as a primary caregiver to a qualifying patient;
- b. Possess, in combination with and as an agent for the qualifying patient, no more marijuana than is necessary for the patient's personal, medical use, not exceeding the amount necessary for a sixty day supply;
- c. Present a copy of the qualifying patient's valid documentation required by this chapter, as well as evidence of designation to act as primary caregiver by the patient, to any law enforcement official requesting such information;
- d. Be prohibited from consuming marijuana obtained for the personal, medical use of the patient for whom the individual is acting as primary caregiver; and
- e. Be the primary caregiver to only one patient at any one time.

1. "Medical use of marijuana" means the production, possession, or administration of marijuana, as defined in RCW 69.50.101(q), for the exclusive benefit of a qualifying patient in the treatment of his or her terminal or debilitating illness.

2. "Primary caregiver" means a person who:

- a. Is eighteen years of age or older;
- b. Is responsible for the housing, health, or care of the patient;
- c. Has been designated in writing by a patient to perform the duties of primary caregiver under this chapter.

3. "Qualifying Patient" means a person who:

- a. Is a patient of a physician licensed under chapter 18.71 or 18.57 RCW;
- b. Has been diagnosed by that physician as having a terminal or debilitating medical condition;
- c. Is a resident of the state of Washington at the time of such diagnosis;
- d. Has been advised by that physician about the risks and benefits of the medical use of marijuana; and
- e. Has been advised by that physician that they may benefit from the medical use of marijuana.

4. "Terminal or Debilitating Medical Condition" means:

- a. Cancer, human immunodeficiency virus (HIV), multiple sclerosis, epilepsy or other seizure disorder, or spasticity disorders; or
- b. Intractable pain, limited for the purpose of this chapter to mean pain unrelieved by standard medical treatments and medications; or
- c. Glaucoma, either acute or chronic, limited for the purpose of this chapter to mean increased intraocular pressure unrelieved by standard treatments and medications; or
- d. Any other medical condition duly approved by the Washington state medical quality assurance board as directed in this chapter.

Sec. 6. DEFINITIONS.

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

5. “Valid Documentation” means:

- a. A statement signed by a qualifying patient’s physician, or a copy of the qualifying patient’s pertinent medical records, which states that, in the physician’s professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the health risks for a particular qualifying patient; and
- b. Proof of Identity such as a Washington state driver’s license or identicard, as defined in RCW 46.20.035.

Sec 7. ADDITIONAL PROTECTIONS.

1. The lawful possession or manufacture of medical marijuana as authorized by this chapter shall not result in the forfeiture or seizure of any property.
2. No person shall be prosecuted for constructive possession, conspiracy, or any other criminal offense solely for being in the presence or vicinity of medical marijuana or its use as authorized by this chapter.
3. The state shall not be held liable for any deleterious outcomes from the medical use of marijuana by any qualifying patient.

Sec. 8. RESTRICTIONS, AND LIMITATIONS REGARDING THE MEDICAL USE OF MARIJUANA.

1. It shall be a misdemeanor to use or display medical marijuana in a manner or place which is open to the view of the general public.
2. Nothing in this chapter requires any health insurance provider to be liable for any claim for reimbursement for the medical use of marijuana.
3. Nothing in this chapter requires any physician to authorize the use of medical marijuana for a patient.
4. Nothing in this chapter requires any accommodation of any medical use of marijuana in any place of employment, in any school bus or on any school grounds, or in any youth center.
5. It is a class C felony to fraudulently produce any record purporting to be, or tamper with the content

of any record for the purpose of having it accepted as, valid documentation under section 6 (5) (a) of this act.

6. No person shall be entitled to claim the affirmative defense provided in Section 5 of this act for engaging in the medical use of marijuana in a way that endangers the health or well-being of any person through the use of a motorized vehicle on a street, road, or highway.

Sec. 9. ADDITION OF MEDICAL CONDITIONS.

The Washington state medical quality assurance board, or other appropriate agency as designated by the governor, shall accept for consideration petitions submitted by physicians or patients to add terminal or debilitating conditions to those included in this chapter. In considering such petitions, the Washington state medical quality assurance board shall include public notice of, and an opportunity to comment in a public hearing upon, such petitions. The Washington state medical quality assurance board shall, after hearing, approve or deny such petitions within one hundred eighty days of submission. The approval or denial of such a petition shall be considered a final agency action, subject to judicial review.

Sec. 10. SEVERABILITY.

If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

Sec. 11. CAPTIONS NOT LAW.

Captions used in this chapter are not any part of the law.

Sec. 12.

Sections 1 through 11 of this act constitute a new chapter in Title 69 RCW.

State Cannabis Penalties

Offense	Offense Type	Max. Jail	Max. Fine	RCW
Possession, 40 grams or less	Misdemeanor	90 Days	\$1,000	69.50.4014
Possession, over 40 grams	Class C Felony	5 Years	\$10,000	69.50.4013
Manufacture, delivery, possession with intent to deliver	Class C Felony	5 Years	\$10,000	69.50.401
Involving a minor in a cannabis transaction	Class C Felony	5 Years	\$10,000	69.50.4015
Distribution to a minor	Class B Felony	10 Years	\$10,000	69.50.406
Drug paraphernalia use	Misdemeanor	90 Days	\$1,000	69.50.412
Drug paraphernalia sale or delivery	Civil Infraction	n/a	\$250	69.50.4121

This is state law. Federal law still applies within the State of Washington and differs greatly from local law.

Mandatory minimum: Any misdemeanor cannabis conviction carries a 24-hour mandatory minimum sentence and a mandatory minimum fine of \$250. The minimum fine increases to \$500 on second or subsequent offenses. See RCW 69.50.425.

Double whammy: The maximum fines and jail time for **all** cannabis offenses double on the second and subsequent offenses. That means a second two-ounce pot bust can net ten years imprisonment and a \$20,000 fine, though sentencing guidelines make such a maximum sentence unlikely for most defendants. See RCW 69.50.408.

Medical cannabis: It is an affirmative defense to violations of cannabis-related laws that the person, possessing no more medical cannabis than is legally allowed, has valid documentation and meets all criteria as a qualifying patient or as a designated provider to a qualifying patient. See RCW 69.51A.

Juveniles: For drug offense convictions of juveniles, the offender’s driver’s license is suspended for one year. RCW 46.20.265.

Sentencing guidelines: The Washington State Sentencing Guidelines recommend sentences for various felonies. For manufacture, delivery, possession with intent to deliver, or possession of more than forty grams of cannabis, the sentence is 0-6 months for the first, second and third offense, and 6-24 months for subsequent offenses if no other offense has been committed.

Paraphernalia: In 1998, the legislature made paraphernalia sales a Class 1 civil infraction, allowing law enforcement to issue tickets to smoke shops without a burden of proof required by misdemeanor charges.

School zone and gun enhancements: A drug crime committed within 1,000-feet of a “school zone,” or while in possession of a firearm, may add mandatory sentencing enhancements to one’s sentence. See RCW 69.50.435, RCW 9.94A.533, and federal law 18 USC 924(c).

Case Law

Conant v. Walters. Federal Appeals Court rules that health care professionals have a first amendment right to discuss cannabis with their patients, and the DEA may not threaten to revoke the licenses of doctors who authorize the medical use of cannabis. 309 F.3d 629 (9th Cir. 2002)

In re Grand Jury Subpoena for THCF Medical Clinic Records. U.S. District Court quashes Grand Jury subpoena for records on medical cannabis patients authorized through The Hemp and Cannabis Foundation. 504 F. Supp. 2d 1085 (E.D. Wash. 2007)

Raich v. Gonzales. U.S. Supreme Court rules that the federal government may prosecute medical cannabis patients who grow their own medicine in states with a medical cannabis law. 545 U.S. 1 (2005)

Roe v. TeleTech. Medical cannabis patients may legally be fired simply for being a medical cannabis patient. 171 Wash.2d 736, 257 P.3d 586 (Wash., 2011)

Seeley v. State. Supreme Court reverses ruling after pro se litigant Ralph Seeley overturned the state's ban on medical cannabis. 132 Wash.2d 776, 940 P.2d 604 (Wash., 1997)

State v. Adams. 148 Wash.App. 231, 235, 198 P.3d 1057 (2009)

State v. Brown. Court of Appeals reverses conviction of designated provider who possessed valid documentation for multiple patients. 269 P.3d 359, (Wash.App. Div. 2, January 24, 2012)

State v. Butler. Court rejects common law

medical necessity defense. 126 Wash.App. 741, 109 P.3d 493 (Wash.App. Div. 2, 2005)

State v. Fry. Medical cannabis authorization is inadmissible if for a condition the court rules is not qualifying. Medical cannabis authorization does not prohibit a search, and is supporting evidence to justify a search. 168 Wash.2d 1, 228 P.3d 1, (Wash., 2010)

State v. Ginn. Court of Appeals reverses pre-trial ruling disallowing patient from raising a medical cannabis affirmative defense. 128 Wash.App. 872, 117 P.3d 1155 (Wash.App. Div. 2 Aug 09, 2005)

State v. Hanson. Court of Appeals rules that a medical cannabis authorization obtained one day after a police raid is admissible in court. 138 Wash.App. 322, 157 P.3d 438 (Wash.App. Div. 3, 2007)

State v. May. 100 Wash.App. 478, 997 P.2d 956 (Wash.App. Div. 3, 2000)

State v. Otis. Court of Appeals reverses conviction of patient disallowed a medical cannabis defense, because the trial court failed to enter written findings of fact and conclusions of law as required for a bench trial. 151 Wash.App. 572, 213 P.3d 613, (Wash.App. Div. 2, 2009)

State v. Shepherd. Authorizations must say a patient "would likely" benefit, not "may" benefit, from medical cannabis. Overturned by legislature. 110 Wash.App. 544, 41 P.3d 1235 (Wash.App. Div. 3, 2002)

State v. Tracy. Supreme Court rules that out-of-state authorizations are not valid. 158 Wash.2d 683, 147 P.3d 559, (Wash., 2006)

Jury Nullification

Judging the law is your right

Jury nullification is the constitutional doctrine which allows juries to judge the validity of the law in question, not just a defendant's guilt. Many laws do not pass constitutional or moral muster, and it is the right and duty of every American to invalidate such laws in the jury box.

One juror has the power to end cannabis prohibition in Washington State. Consider that. One juror. Imagine a time when prosecutors throughout our state decline to prosecute cannabis cases because they fear this one juror. Such is the power held by we, the people.

Judges will not tell jurors this

Judges will not inform juries of their right to judge the law in question -- in fact, most judges will specifically instruct juries that the jury may only decide the facts of the case, and that the judge is the sole arbiter of the law in the case. It used to be that American judges had a legal obligation to inform juries of their inherent right to judge the law, but that ended with the 1894 U.S. Supreme Court decision in *Sparf v. U.S.* which stated federal judges were not required to inform juries of their inherent right to judge the law.

The *Sparf* case overturned a century of American jurisprudence. In 1794, a nascent Supreme Court ruled precisely the opposite. America's first Chief Justice, John Jay, wrote: "It is presumed, that juries are the best judges of facts; it is, on the other hand, presumed that courts are the best judges of law. But still both objects are within your

power of decision... you [jurors] have a right to take it upon yourselves to judge both, and to determine the law as well as the fact in controversy."

Jurors won't be prosecuted

A juror can not be punished for the verdict they return. In rare circumstances -- mainly lying during "voir dire" questioning -- the state may attempt to prosecute a juror, but this is an extremely rare incident, and is rarely successful. In 1999, Colorado hemp activist Laura Kriho faced such a prosecution after failing to fully answer several questions during voir dire, and she was acquitted.

Juries are the people's conscience

Our founders intended for jurors to have the final judgment on the laws of the land. By refusing to enforce bad laws, the American people may keep their "check-and-balance" government in check and in balance. This has been done with unjust laws during fugitive slave trials, alcohol prohibition trials and anti-war protestor trials. When the law demands a cannabis conviction, and a single juror votes to acquit based on moral conscience, that one person has effectively stopped tyranny and injustice.

Learn more at FIJA.org

The Fully Informed Jury Association is the leading activist organization educating citizens about their right to nullify bad laws in the jury box. Visit them at www.fija.org.

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The following attorneys are members of the Cannabis Defense Coalition activist cooperative and our Legal Committee. These listings are sorted alphabetically by first name.

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